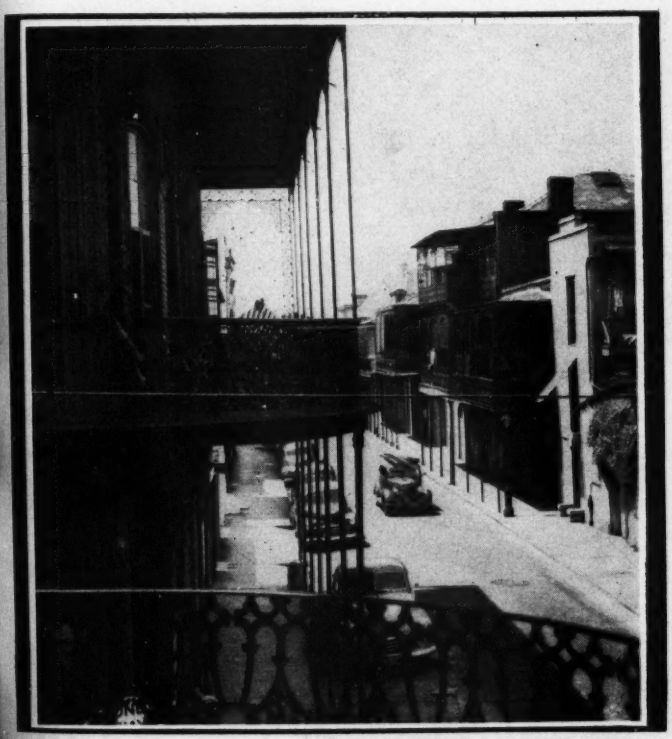
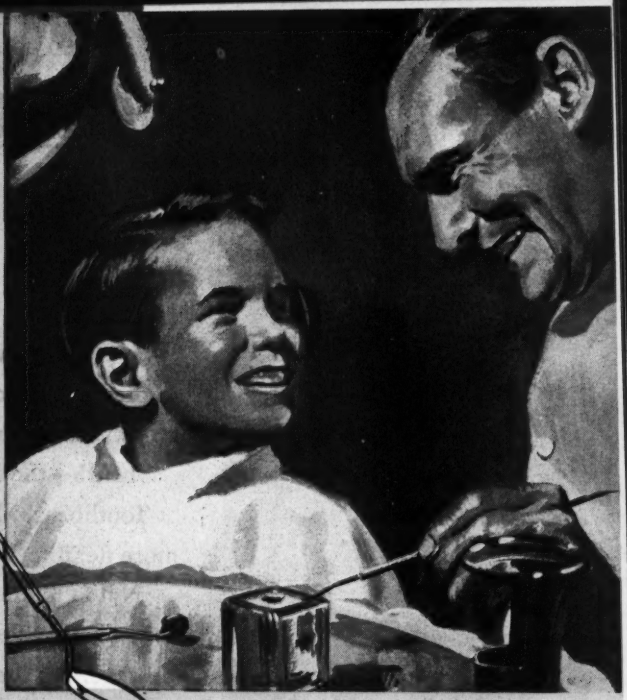
Oral Hygiene

SEPTEMBER 1951



An old residential section in New Orleans, Louisiana.
New Orleans Dental Conference, November 11-14.

In this issue: *Three Views of Focal Infection*



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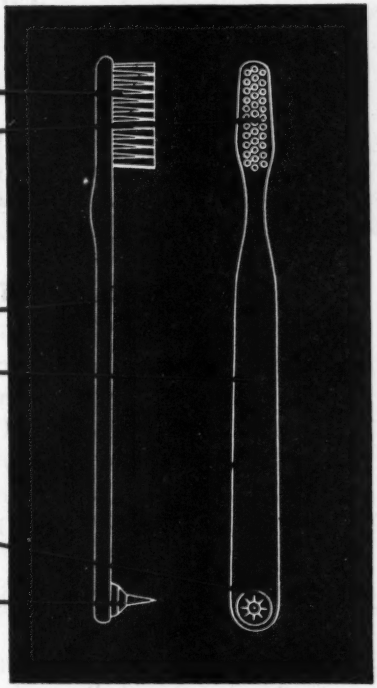

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The Publisher's CORNER

By Mass

No. 362

Department of Missing Persons

LATELY, you may have noticed that the CORNER has been reuniting long-lost friends. The piece in the June issue about Doctor Charles P. Weinrich, ORAL HYGIENE's 90-year-old Louisiana pal who is affectionately known as Junior, brought a letter from Doctor Harry W. McLeckie of Paris, Texas. Harry's letter was published in this space last month as a guest CORNER entitled "God Bless Junior!"

To wise up those who came in after the curtain rose: Harry McLeckie had lost track of Junior since he last saw him in Honduras thirty-eight years ago—until he spied Junior's picture in this department. It was Junior who influenced Harry to become a dentist, although Harry has only now realized it. "Now I know it was then that Junior gave me the 'key' to what was to be my own life work."

And now there's been still another reunion! Charlie Ferguson who is in the dental business down in San Antonio, Texas, read

the same June CORNER and right away hopped a plane for Louisiana. Charlie hadn't seen his old friend Junior for fifty years, and had had no notion of his whereabouts until he read the CORNER.

Charlie and Junior had both worked for S.S. White's Chicago branch in 1896. Charlie wrote me: "Junior had been good to me when I was a kid and I just felt it my duty to go to see him. He tells me he has never been sick a day in his life, and when people ask him how old he is, he says he isn't old—that he has just lived a long while. If God lets *you* live to be ninety, and in the same physical condition as Junior, you will be a wonder."

The June CORNER told also about Doctor Earl Crary of Cando, North Dakota. Believe it or not, but the piece about Earl resulted in still another reunion. With whom do you suppose? None other than Charlie Ferguson's brother and business partner, Fred Fougerousse. (Years ago, Charlie simplified the family name; Fred didn't.) Fred knew Earl Crary when Earl was studying dentistry at Northwestern close to forty years ago. In those days, Fred was managing White's college branch at Northwestern. When he met Earl, Fred says, "I was selling Black's cutting instruments and a lot of other items to the boys from the country when they arrived with their carpetbags and the few pesos Papa gave them when they left home. Earl arrived for his freshman year about 1913, and he had the immediate misfortune of running into me at the college branch."

Fred thought Earl might have forgotten him after the lapse of years. But there had been no forgetting. Earl writes me: "I remember Fred Fougerousse very well indeed. He was one of my real friends and I liked him a lot."

Two people were *not* reunited by the June CORNER—the two people the CORNER was about, Junior Weinrich and Earl Crary. They had never even heard of each other before they read about themselves in these pages three months ago.

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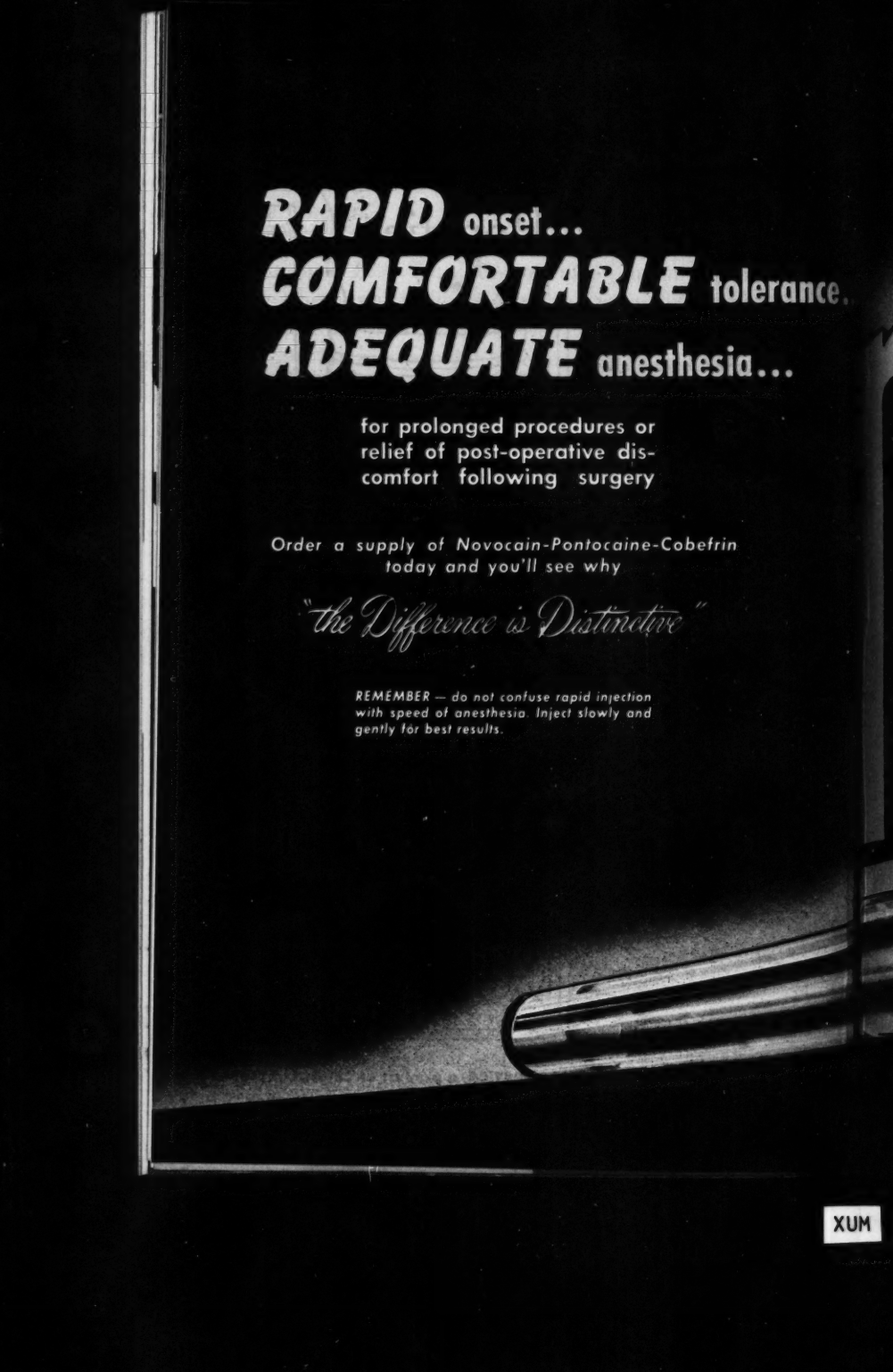
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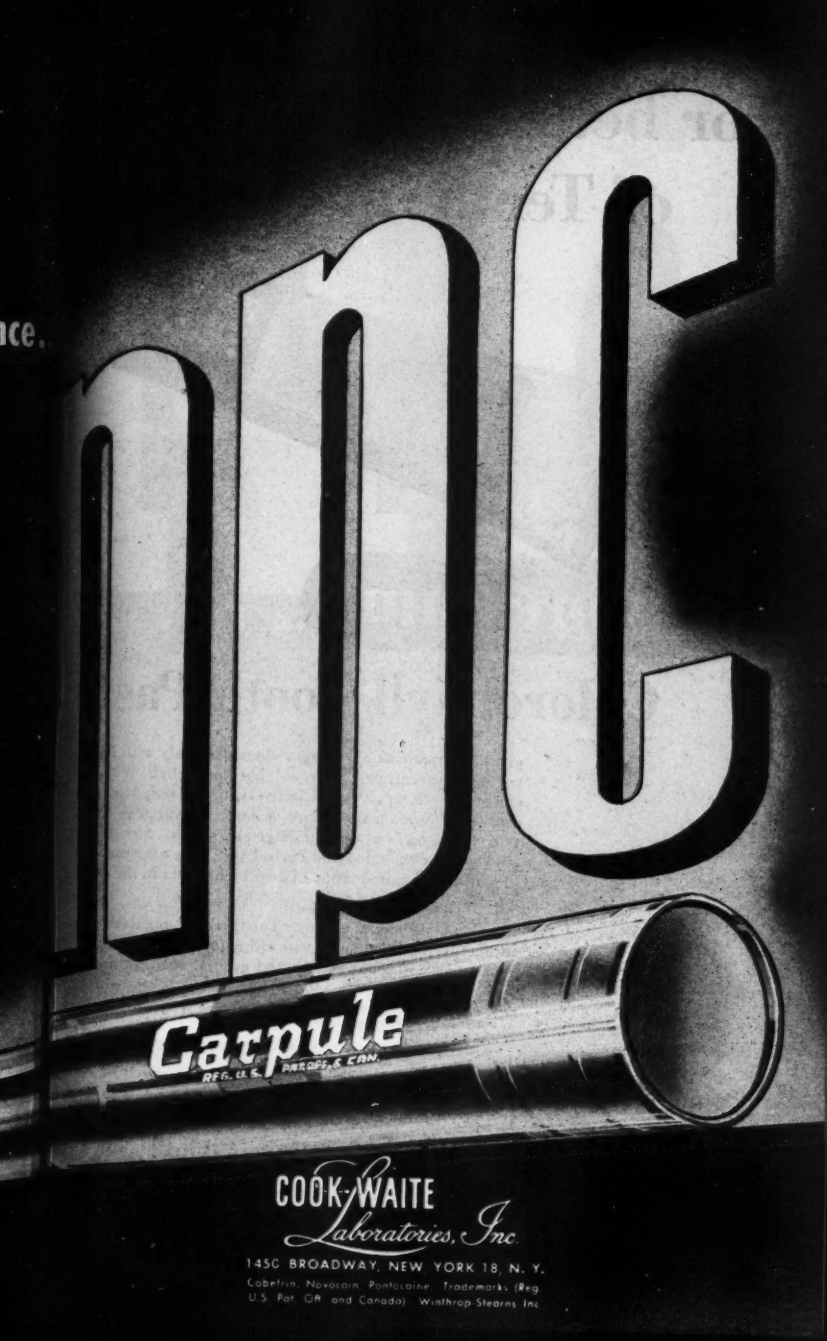

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*Hein, J. W., and Shafer, W. G.: Pennsylvania Dent. J. *16*:221, 1949. Rapp, G. W., and Gurney, B. F.: Paper read at International Association for Dental Research Meeting, Chicago, June 24-25, 1949.

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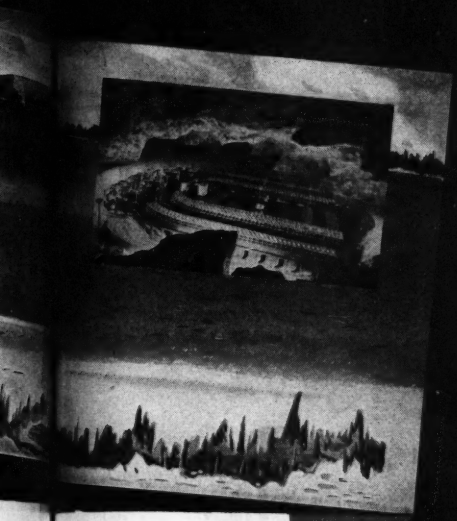

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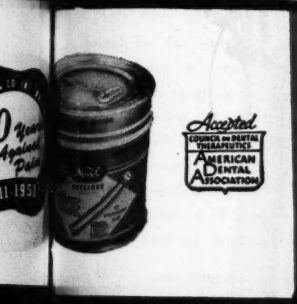

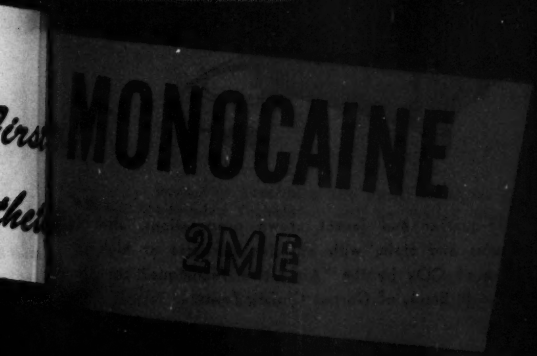

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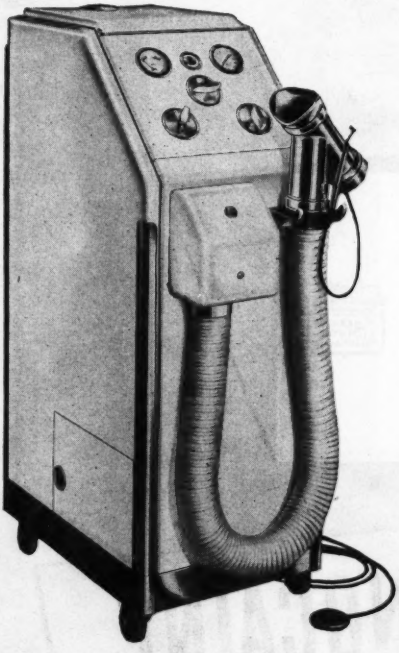

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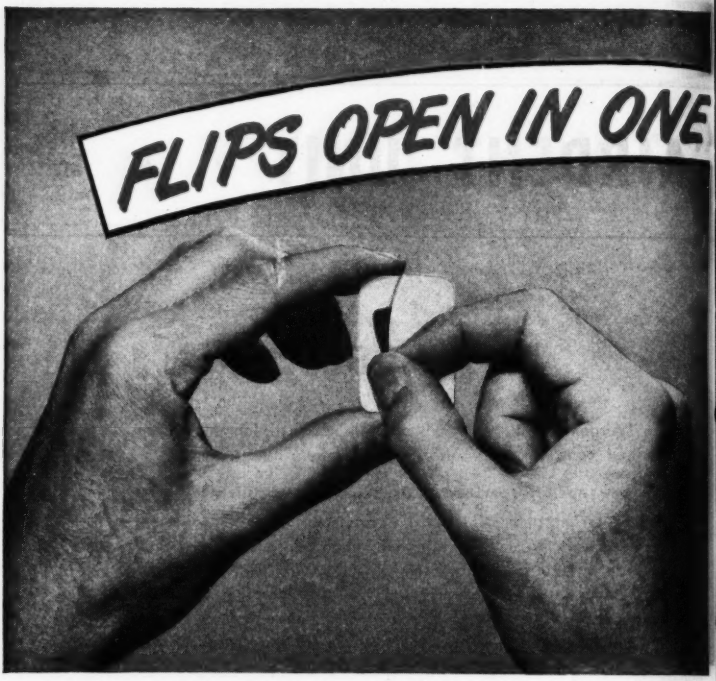

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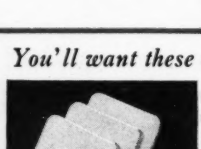

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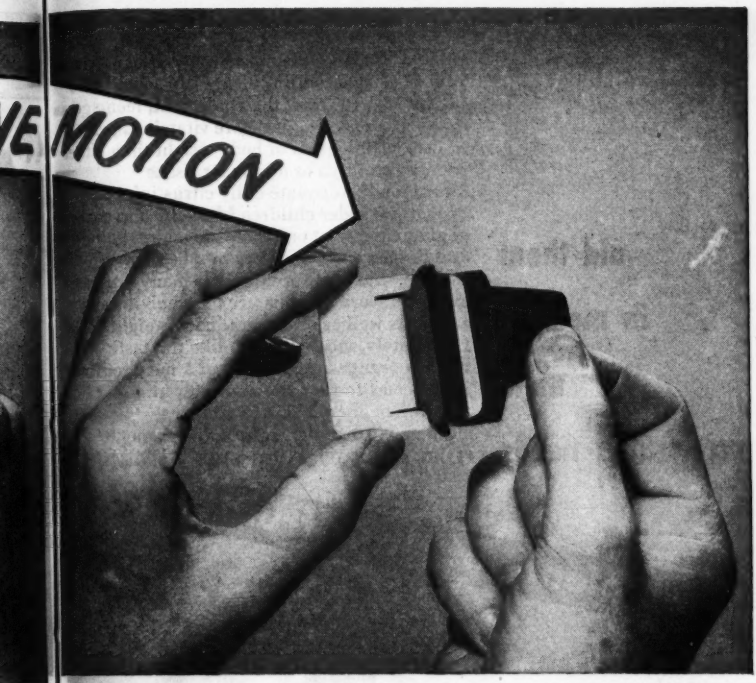

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References

1. Armstrong, W. D.: J. Dent. Research, 27:376, 1948. 2. Hanke, M. T.: Diet and Dental Health, Chicago Univ. Press, 1933. 3. Howe, P. R., et al.: J. Am. Dent. A., 28:1089, 1941. 4. Joslin, C. L., and Bradley, J. E.: Personal Communication. 5. Mead, S. V.: Proc. 52nd Ann. Meeting Fla. State Horticultural Soc., 1939. 6. Ibid.: Am. J. Orthodontics & Oral Surg., 26:968, 1940. 7. Quart. Rev. Pediat., 4:170,319, 1949. 8. Roworth, R. H.: J. Dentistry Child., 13:73, 1946. 9. Stearns, G.: J. Dent. Research, 27:397, 1948. 10. Sterwick, C. A., et al.: J. Nutrition, 33:539, 1947.

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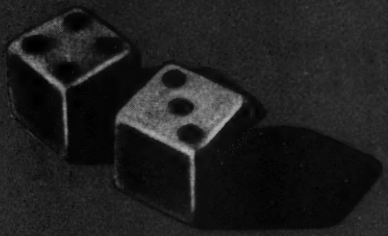

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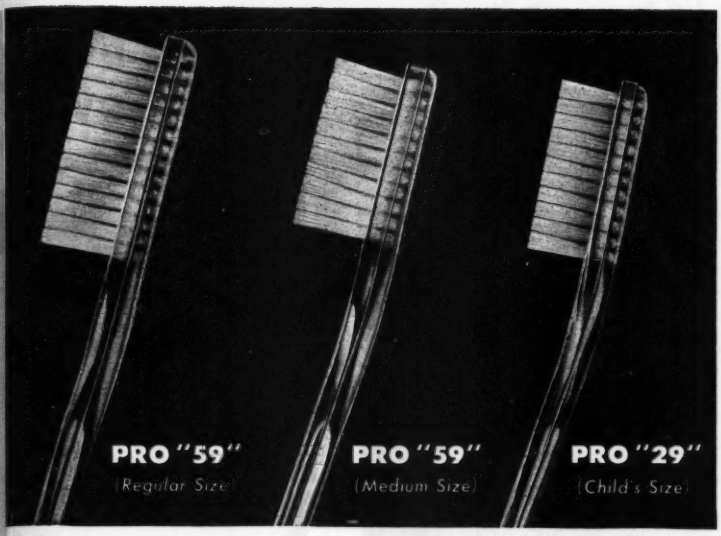

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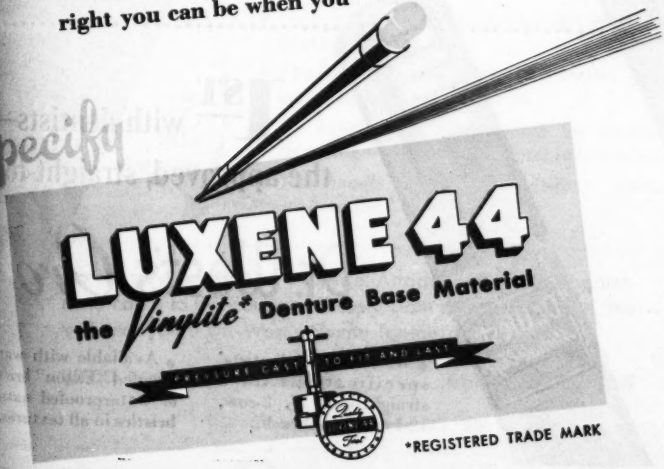

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VOL. 41, NO. 9 **Oral Hygiene** SEPTEMBER 1951

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Circulation more than 73,000 copies monthly

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Picture of the Month

DOCTOR JOHN O. Peterson, former Brooklyn dentist, is showing his five-year-old grandson, Johnny Ceilly, the medal recently awarded him by the Swedish Government. In 1884, as a boy of 17, Doctor Peterson came to America. Still much aware of the charitable activities of the 83-year-old dentist over the past half-dozen decades, the King of Sweden bestowed upon Doctor Peterson the Royal Order of Vasa Knighthood, "in recognition of his lifelong devotion to the humanitarian work and ideals of his native land."—*Photograph, courtesy of* The Brooklyn Eagle.

Ten dollars will be paid for the picture submitted and used in this department each month. Send glossy prints with return postage to ORAL HYGIENE, 708 *Church Street, Evanston, Illinois.*

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THREE VIEWS
on Focal Infection

Poor Health Isn't Caused by Teeth

CHICAGO, ILL. (AP) — You're probably wrong if you blame infected teeth for your aches and pains.

That view was expressed Thursday in an exhaustive study prepared by 12 University of Michigan dental and medical scientists for the American Dental association.

The report said there is little, if any, scientific evidence to support a 40-year-old theory that removal of infected teeth will relieve arthritis, rheumatic heart disease, and kidney, eye and skin disorders.

Dentists of Boston, Baltimore, and Chicago discuss dental foci of infection and systemic health as reported in the *Journal of the American Dental Association.*

I. *My Experience with Focal Infection*

WILLIAM BYRON KINNEY, D.D.S.

IN MY thirty-five years as a general practitioner I have seen some amazing things and heard some remarkable stories, but the real shocker hit when, reading the *Chicago Tribune* on June first, I came upon the following article by Roy Gibbons: "Survey Lifts Blame on Teeth for Diseases."

"Thousands of teeth over the years have been pulled needlessly in a futile effort to overcome various chronic diseases, the *Journal of the American Dental Association* asserted yesterday.

" 'Little or no scientific evidence exists,' the *Journal* said, 'to support the theory that infected teeth in themselves are the major cause of arthritis, heart ailments, kidney infections and disorders of the eyes or skin.' "

I checked the article with my *Journal* and found them substantially in accord, but the amazing statement by Grossman on page 620[1] that "it is disconcerting but true that practically every investigation dealing with the pulpless tooth and made prior to 1936 is invalid in the light of recent studies," was, according to my personal observations and experiences, difficult to accept. I recalled the morning in March 1927 when I awakened with a terrific pain in my left arm, extending from my neck to the tips of my fingers. The thumb, first and second fingers were completely numb, a condition which lasted for three weeks. During this period I could not raise my arm and the pain was severe—diagnosis: neuritis.

I lost no time X-raying everything in my oral cavity and came up with seven "dead" teeth, five with well-filled root canals, two showing bone changes at their apexes. Being a follower of the then prevailing philosophies of Hunter, Rosenow, and Billings, I immediately got in touch with my good friend, Earle Thomas, M.D., D.D.S. With the aid of his nurse and their gas machine, he had the seven teeth out of my mouth and into the proper receptacle in jig time.

[1] An Evaluation of the Effect of Dental Foci of Infection on Health, JADA **42**:620 (June) 1951.

On the basis of today's findings by the ADA's Council on Dental Health, I would still have those "dead" teeth and probably my neuritis! In about a month the neuritis cleared up. With it went an aggravated case of cold feet—physical, not figurative, I hasten to explain—as during the previous winter my circulation was such that I could not sleep comfortably without encasing my feet in heavy socks. My general health improved, including a gain of a few pounds of much needed weight.

Head Pains

Irene S, age 21, came to me complaining of severe head pains. Roentgenograms showed four treated anterior teeth with well-filled root canals and no apical involvement. She wanted to know if the extraction of the four "dead" teeth would relieve her condition, to which I replied that I did not know and that the only way, in my opinion, to find out, was to remove them. This she was unwilling to do and left. About three months later she returned, said she had been to the Mayo Clinic where the opinion given was in accord with mine, and she decided to have the teeth removed. With the extraction, her condition improved almost immediately and shortly cleared up. Whether or not the teeth were the cause of her distress, no one will ever know. I can only give the evidence as I found it.

Then there was the case of Mrs. H who complained of headaches, rheumatism, poor digestion, fatigue, and what not. Both the roentgenogram and visual examination showed unhealthy conditions to the extent that I advised extraction of all her teeth. The next day a belligerent husband came to tell me he would never consent to such a radical procedure without a great deal of further consultation, which I assured him he would have to have before I would consent to undertake the operation. He left in an aggressive frame of mind, and I did not expect to hear from them again. But a month later they came in, all smiles, said they were satishfied with my diagnosis, and wanted me to proceed. The teeth were removed, her complaints vanished; and at the last reports she was doing well with her dentures. Did the teeth cause her difficulties? I do not know. But when they were removed, her pains apparently went with them.

Referred by Oculist

Joe, the six-foot farm boy from Iowa, came to me at the request of his oculist. He was suffering from eye disturbances and headaches. The roentgenogram showed two good-sized areas of bone destruction at the apexes of a lower molar. After a prolonged talk on the serious effects of infected teeth, during which he insisted the tooth had never given him any pain or annoyance, he reluctantly agreed

to its removal. My usual routine when extracting is not to let the patient see the tooth, but as I lifted this one from its socket, Joe quickly leaned forward and said, "Hey, Doc, let's see it." I held it with the forceps: Joe took one look at those two gooey sacks dangling from the root tips and promptly fainted! Whether that extraction helped Joe's eyes or cured his headaches, I don't know, as I have not seen him since, but I am sure he left me with an awful headache!

There is no doubt in my mind that a great many harmless teeth have been lost through too much enthusiasm on the part of dentists and physicians in their search for cures. But I feel that on the basis of observation and experience, I can go along with Denston who, following a study of chronic periapical lesions, concluded, "I am convinced that all periapical lesions are to be regarded as potential sources of infection. I consider that the presence of vessels in the fibrous capsules of chronic periapical lesions furnishes direct communication between the infective process and the general circulation. I consider that the majority of granulomata remaining *in situ* after the extraction, degenerate and eventually become replaced by normal bone tissue."

With Alexander Pope I ask, "Who shall decide when doctors disagree?" There may be considerable latitude of disagreement on the degree of bodily harm from the presence of dental granulomas, but I was greatly relieved to find that on page 639 of the *Journal* there was universal agreement that completely impacted teeth can be disregarded as foci of infection.

On one point in our controversy I believe the majority will agree: that wide publication of articles such as appeared in the *Chicago Tribune* will not enhance the confidence of the public in the ability of dentists or physicians as dental diagnosticians. To the average reader who is not too discerning or analytical, the caption of the *Tribune* article could be completely misleading and the source of much disagreement between patient and operator. It seems to me that this is a good spot for the well-organized and capably directed Bureau of Public Information of the ADA to take over.

5613 *Lake Street*
Chicago 44, *Illinois*

FOCI OF INFECTION BOOKLET TO BE SENT TO 125,000 PHYSICIANS

MORE THAN 125,000 reprints of the articles on dental foci of infection from the June issue of *The Journal of the American Dental Association* will be distributed in pamphlet form to members of the American Medical Association in September by the Church and Dwight Company, Inc., of New York, it was announced this week. The company manufactures Arm and Hammer baking soda. The booklet contains the special report by twelve dental and medical scientists on the effect of dental foci of infection on general health. The report concluded that there is little or no scientific evidence to support the theory that infected teeth in themselves are a major cause of arthritis, heart ailments, kidney diseases, eye disorders or skin diseases.—*ADA News Letter*, August 1, 1951.

II. *The Focal Infection Dilemma*

JOHN W. COOKE, D.M.D.

THE JUNE 1951 *Journal of the American Dental Association* devoted about seventy pages to what was intended as a rational evaluation of *teeth* as foci of infection. More accurately, this information *did* have to do with *teeth* and their supporting structures.

It is common sense to examine the probable effect of this information on:

(a) dentists

(b) the public

There is a wide gap between clinical teaching, research in dentistry, and clinical private practice. This gap is wider now than it was ten or fifteen years ago, possibly due to the application of experimental medicine to the thinking of teachers in dentistry. Clinical teaching as to pulpless teeth has changed. Students see few such cases except between the beaks of extracting forceps, and their approaches to such teeth in private practice are likely to be somewhat impatient. Thus, obscure neuralgias suggest the removal of unerupted third molars, and the young practitioner may do a thriving business in prosthetics of one kind or another.

The optimum objectives of dentistry seem to be *no* caries, and *no* periodontal disease. Both objectives are far distant despite fluorine, the so-called ammonium ion, and various attempts at public education. Between cup and lip, there is and will be needed a wide variety of therapeutic attempts to keep human teeth functioning. This suggests a little imagination and the unqualified admission by dentists that teeth grow old, usually in advance of the rest of the body, and that a number of compromises are possible. Indeed, they are indicated more frequently than many dentists realize.

If the conclusions of the ADA symposia are correct as they may be, at least in part, dentists may decide to face the reality of conservation rather than the easy road of extraction and replacement. This will be a difficult undertaking; for conservation, maintenance, and repair are undramatic, relatively unprofitable, and contrary to the American term "big."

From the somewhat guarded manner of the article, one is obliged to conclude that the role of infected teeth has been exaggerated. Possibly this is a good thing. Possibly, Rosenow's hypothesis of elective localization will now be brought out from its dark closet, dusted off, and again put to work. Probably, although this current piece of work merits careful reading by dentists, it will not be read widely, because dentists simply do not read. Don't ask why; it isn't because they do not know how.

Public Seeks Information

The public, however, *does* read. Your patients will not see this ADA material, because it is not available to them. They will, however, study the newswriters' version carefully, because it has already been offered to them. This version, written to attract attention and thus to be read, jumps the gun on a rational interpretation of what little dentistry knows about poor teeth and poor health, and adds to the confusion already experienced by many thinking dentists. It may be timely to state that the source material employed has been available to the dental profession for some years. The evaluation of this source material, one might suspect, has something to do with which side of the fence you stand on.

Your patients are interested in getting well when they are ill. They are the less interested in staying well. This is similar to the emotional approach of the evangelist. Lifting a lost soul out of the gutter is easier than keeping the human animal from tripping and falling in. Your patients want to stay out of the gutter and achieve salvation, largely through *your* efforts. Unfortunately, the road to repair and maintenance is dull and hard and the scenery lacks the breath-taking atmosphere of dramatic accomplishment.

As a thought-provoking piece of work, the current ADA effort ranks A— A for effort. As an addition to the art of public relations, it has laid an egg, possibly a large egg. What becomes of the egg is anybody's guess. Should news get tight, the egg will not grow; that is, in any public sense. However, it is a safe bet that dentists will be asked and expected to answer a number of questions.

60 *Charlesgate West*
Boston 15, *Massachusetts*

III. *What Can We Tell Our Patients About Infection?*

JACK SHOBIN, D.D.S.

FOR FIFTEEN years as a dental practitioner, I have preached to my patients the importance of a healthy mouth in relation to systemic health. I pointed out to them that infected teeth, particularly those with a periapical involvement, can cause arthritis, endocarditis, iritis, and nephritis. The possibility of systemic involvement was one of my main reasons for suggesting full mouth roentgenograms for every patient. I felt that I was performing an important diagnostic function when I was called upon by a physician to take full mouth roentgenograms of a patient to search for a focus of infection. I would attempt to trace the lamina dura, often with a magnifying glass, then test a doubtful tooth for vitality, always cognizant of the fact that it is important to eliminate an infected tooth that may aggravate or cause a patient's illness.

I remember the little shrivelled woman, twisted with age and arthritis, who was carried up the steps to my second-floor office. It was a great thrill and satisfaction two weeks later to see her climb the steps unassisted. I felt then for the first time that I was a member of the healing profession in the full meaning of the word. No doubt, other dentists can recall similar incidents and the consequent boost to their professional pride.

Now all that is gone! In a comprehensive survey and study of the effect of dental foci of infection on health, an agency of the American Dental Association has arrived at the conclusion that modern research regards with skepticism the theory of focal infection as propounded by Rosenow and Billings forty years ago. There is no proof, says the report, that rheumatic arthritis is caused by infection; hence, the elimination of infection is of little consequence. Focal infection has no connection with dermatosis. Scientific facts do not link dental focal infection with ocular disease. Infection in the urinary tract is caused by the colon bacterium, and thus is totally unrelated to in-

fected apexes of teeth. The connection between valvular heart disease and dental infection is more or less of a "don't nature." If ever you extract teeth for a patient suffering from subacute endocarditis make sure he is premedicated with penicillin, or he may die from bacteremia.

What *Is* True?

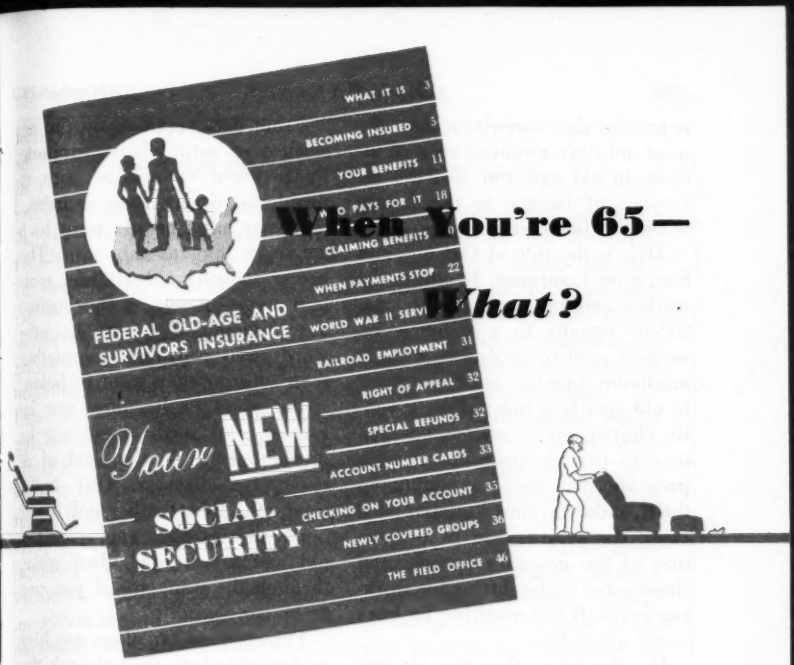
The report points out that all this does not mean that the dentist should not suggest the removal of infected teeth. Such removal may improve the general health of the patient, but will not have direct effect upon his specific illness. The simplicity of cause and effect is gone. The idea of focal infection as a basic ingredient of dental health service is nullified.

If we start discarding principles which we have accepted for forty years, where do we stop? How do we know that removing infected teeth helps the patient *at all?* Now that we think of it, we did come across in our office quite a few robust patients with pronounced degrees of periodontal disease. Who knows whether the lack of proper mastication of food causes those gastro-intestinal ulcers about which we studied in college?

The focal infection theory lent the dental profession added prestige and established greater cooperation between the physician and the dentist. Therefore, I cannot understand why an agency of the dental profession went out of its way and undertook an extensive research project to prove the fallacy of the theory. Such a project might have been undertaken by our enemies, if we have any. Accordingly, from now on, the physician will be justified in dropping the dentist from any consultation about a patient, since infected teeth have no specific bearing upon a patient's illness. The truth, of course, is important, but does anyone know with conviction what the truth is? The whole project is of a negative nature—a refutation of a forty-year-old theory without one positive substitution. There is no doubt that it will do the profession considerable harm. Whether or not the patient will benefit remains to be seen.

Let us hope that the report is merely a rebellion against the panacea of indiscriminate extractions as practiced by overzealous focal infection adherents. Let us also hope that the report is only a transitory phase out of which something positive will grow, lest the healing mantle slide off the shoulders of our profession and we are reduced to the status of mere relievers of toothaches and cosmeticians.

2129 *East Monument Street*
Baltimore 5, *Maryland*



When You're 65—What?

BY EDWARD N. NOVOTNY*

Self-employed dentists excluded from Social Security family insurance and retirement income.

FOUR AND a half million men and women who work for themselves are now covered by Old-Age and Survivors Insurance. Another 5,000,000 wage earners and salaried employees are paying Social Security taxes for the first time.

When you include those contributing to other public retirement systems, you will find that nine out of every ten people are protected by some kind of basic family insurance program.

Our 1950 census recorded a population of 151,000,000,* an increase of 19,000,000 in the last decade, but the greatest increase by far was in the very young and very old categories.

In other words, that part of our population that is *actually* and *potentially* dependent increased far out of proportion to those in the productive age group of 20 to 64.

This emphasizes an area where the need for a continuing income

*Manager, Social Security Administration, Evanston, Illinois. This article has been prepared at the request of the Editor of ORAL HYGIENE.

is greater than anywhere else. We need not only a continuance of income in old age, but also the assurance of income to the family when the breadwinner dies.

That is the role of Old-Age and Survivors Insurance. It allows the worker and his employer to contribute equally to a common insurance pool to guarantee a basic minimum income after death or in old age. It is not a dole, a public charity, or a system competitive to private insurance. It is a program that sets a premium on thrift, industry, and initiative; because the returns are in proportion to the insured's income and standard of living during his working years. It is something he buys —not a handout.

Do you know that *one* in *four* of our older citizens must rely on some form of public assistance in their declining years? Once they reach 65, actuarial tables give them twelve more years to live. Social Security is designed to eliminate such dependency as far as possible and that is exactly what it has been doing since its liberalization last year.

Old-Age Problems

After raising a family and living through depression and inflation, how many people are able to accumulate enough to retire in old age? I'll tell you: *One in ten.* An annuity of $100 a month at 65 will cost about $15,000 cash. Will you have that when you reach old age?

From data supplied by the new science of gerontology, supported by personal experience with the problems of our older citizens, I find that most people want to be active as long as they can. They prefer to work, or at least maintain some interest in the business or professional world. In other words, they still want to contribute their efforts; they want to belong.

But good health does not last forever and medical science has much to learn in the field of degenerative diseases. Our bodies wear out. Even with good health, opportunities for employment in old age are limited. Just glance through the want ads if you need to be convinced.

Private pension plans are highly desirable but, even though they increased from 200 in 1915 to well over 14,000 today, their coverage is far too limited. Obviously they do not include those who work for themselves.

Thus by the process of elimination, Social Security is the only answer to the problem. It is the basic plan of protection, to be supplemented, of course, by private insurance, savings, and other investments that the individual is able to accumulate.

Revised Program

Last year Congress drastically overhauled the Social Security Act because it was frankly inadequate. It covered only 60 per cent of those who worked for a living and its

THE DENTIST AND SOCIAL SECURITY

Self-employed dentists have no type of basic social insurance protection because the House of Delegates of the American Dental Association has gone on record as being officially opposed to coverage. Congress has listened and concluded that the individual practitioner has not indicated a desire for coverage. This exclusion applies to the self-employed dentist only, because the law specifically exempts the practice of dentistry only if the practitioner is not working for someone else.

Most non-farm self-employed were brought under Social Security January 1, 1951. As a whole, these people are older than those who work for salary or wages. Fifty-five per cent are in the 45 or older age group, compared with 32 per cent in that same age group who work for others.

The self-employed specifically exempt include: farm operator, physician, lawyer, dentist, osteopath, chiropractor, optometrist, naturopath, veterinarian, architect, certified public accountant, licensed or registered accountant, full-time practicing accountant, Christian Science practitioner, professional engineer, funeral director.—*The Editor.*

payments were too low. Remember, the rates were established back in 1939 when we were just emerging from a depression. It was a completely new program with a deliberately conservative beginning. It was to be improved with experience.

The result of our experience was these three major changes:

1. *The old benefit amounts were increased an average of 77 per cent, but on a sliding scale.* (Retirement payments ranged from $10 to $46 per month with a national average of $26 a month!)
2. *Coverage was extended to* 10,000,000 *more workers as of January* 1951.
3. *Payments under a further liberalized formula will begin the middle of next year.* They will range from $20 to $80 a month for retirement and maximum benefits of $150 a month.

The law in effect up to August 1950 and the new law dovetail and will effect a gradual transition until, in the near future, virtually all payments will be made under what we call the "new start" provisions. I will limit myself to de-

scribing just these because they apply especially to the self-employed; but remember that people who are insured under both the old and the new laws will receive the higher of the two benefits. These range from $20 to $68.50 and $20 to $80 respectively.

Before anything is payable, *you must first be insured*. This means that you must have worked half the time from January 1, 1951, up to age 65 or death, with a minimum of a year and a half. Once you have worked ten years, you are permanently insured. Death payments will be made if you have worked one and a half out of the three years before death.

The two general types of payments may be classified as follows:

1. Retirement:
   (a) To the worker at 65.
   (b) To his wife at 65.
2. Survivorship:
   (a) To the widow of any age with children under 18.
   (b) To the children themselves.
   (c) To the 65-year-old widow.
   (d) To a chiefly dependent parent at 65.
   (e) To a divorced wife taking care of her children.

The amount of your monthly old-age insurance payment depends upon your average monthly income in work covered by the law. The amount paid to other members of your family is figured on your own benefit. Your wife receives one-half; widow and dependent parents, three-fourths; first child, three-fourths; and each succeeding child, one-half. A small lump sum of three times your monthly old-age benefit is also payable at death.

Basis for Benefits

Thus, total family benefits depend on three things: Your earnings, the number of dependents, and their age.

Here is an example of how the "new start" works:

John C. Smith, who operates a small drug store on Main Street, will be 65 on January 15, 1963. Being self-employed, he first came under Social Security January 1, 1951. His net profits average somewhat over $3,600 per year (the maximum taxable earning). His wife is five years younger, and he has two children, age 12 and 14.

John can retire at 65 and draw $80 per month. When his wife reaches that age, she draws an additional $40 per month.

If John should die in a couple of years, his widow would receive $150 a month for herself and the children until the older child reaches 18. Her payments then drop to $120 a month until the younger child reaches that age, when they will cease altogether. At 65, if she does not remarry, she will draw $60 per month as long as she lives.

This is the breakdown of the

figures:

John's old-age benefit:	$80
Wife at 65: One-half or	40
Total	$120
Widow: ¾ of $80:	$60
First child: ¾ of $80:	60
Second child: ½ of $80:	40
Total	$160

Note: Since the maximum payable is $150, each check will be reduced proportionately.

When the older child reaches 18:

Widow: ¾ of $80:	$60
Second child: ¾ of $80	60
Total	$120

(No reduction will be made since the total does not reach $150.)

Widow at 65: ¾ of $80: $60

These amounts are payable if John works continuously at $3,600 per year. In order to draw the *minimum* retirement benefits of $20, his net income from self-employment must be at least $400 *a year for six years.* (One-half the time from January 1, 1951, up to January 1963.)

If John were self-employed for six years, earning $3,600 each of the six years, his average monthly income for the twelve years would be $150 a month instead of $300 and his old-age retirement benefit, $65.

Thus, under the "new start," old-age benefits range from $20 to $80 per month, depending upon your average monthly earnings. For a $100-a-month average income, the payment will be $50.

If John should die before 65, you would figure his basic old-age benefit in the same manner as if he had reached 65 on that date.

These benefits are paid for out of a special trust fund built out of employer and employee contributions. They do not come out of general tax revenues. The accompanying table shows the rates and scheduled increases.

The self-employed will pay their Social Security tax with their income tax return March 15 of every year.

No benefits are payable if you earn over $50 a month in covered employment. The reason for the limitation is simply to hold down the cost of the program to a reasonable figure. Once you are 75, there is no limitation. Self-employment income up to $600 a year will not affect your payments. However, the number of monthly benefits not payable will not be more than the number of months in which you rendered substantial *service* for *over the* $50 *limitation.* If you merely have an investment in a business and do not participate in its operation, you are entitled to your Social Security.

We are not interested in your net worth or the size of your bank account. There are only about a dozen questions on the application for old-age benefits and they are mostly for identification. The benefits belong to *you* and *your family*

SCHEDULE OF RATE INCREASES

Calendar Year	Employer (per cent)	Employee (per cent)	Self-employed (per cent)
1951-53	1-½	1-½	2-¼
1954-59	2	2	3
1960-64	2-½	2-½	3-¾
1965-69	3	3	4-½
1970 and after	3-¼	3-¼	4-⅞

because *you worked for them and paid for them.*

This is only a generalization of the most important sections of the new Social Security Act. The Social Security Administration publishes an informative 47-page booklet called YOUR NEW SOCIAL SECURITY which goes into greater detail than the background I have furnished. I would certainly recommend that you get a copy of this booklet and study it at your leisure. It can be obtained free of charge from your nearest Social Security office. It is the finest explanation I have seen on both the old and the new law. If you prefer, I will be glad to mail you a copy.

As you finish this, many questions will rise in your mind. I suggest that you take them to your local Social Security office where our people will be glad to go out of their way to give you all the facts at hand and clarify for you the program they are charged to administer.

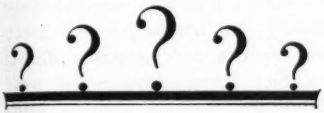
1603 *Orrington Avenue*
Evanston, Illinois

THE COVER

THE QUAINT ironwork of the balconies shown on our cover this month is characteristic of the French Quarter and part of the charm of New Orleans. The lace iron dates back to the time of the Creoles who, in a desire to outdo their neighbors, succeeded in producing these elaborate and unique designs.

Dentists from the United States and Latin America will have an opportunity to visit this historic part of New Orleans while attending the New Orleans Dental Conference November 11 to 14 at the Roosevelt Hotel. Doctor Meffre R. Matta, 629 Maison Blanche Building, New Orleans, is secretary of this important meeting.

So You Know Something About DENTISTRY!



QUIZ LXXXIV

1. Porosity in casting is caused by (a) shrinkage of metal, (b) occluded gases, (c) distortion of molds _____

2. What is odontectomy? _____

3. Which of the following tend to resist general anesthesia? (a) athletic-type persons, (b) persons who are addicted to excessive smoking, (c) excessive alcohol or drug users, (d) persons who have been laboring under a great stress or excitement _____

4. Penicillin may be administered (a) intramuscularly, (b) intravenously, (c) orally, (d) topically _____

5. The chief virtues of copper amalgam are (a) setting time, (b) antiseptic quality, (c) adaptation and adherence to the margins of the cavity. _____

6. For children, the amount of ethyl chloride given at one administration should not exceed (a) 2, (b) 5, (c) 10, cc. _____

7. What determines the distal extension of the mandibular denture base? _____

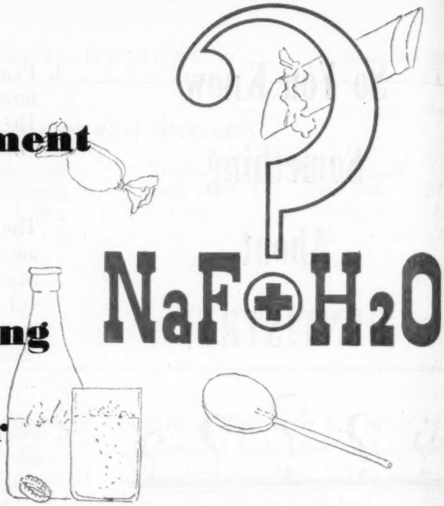
8. Which of the following are found usually in inlay wax? (a) carnuaba, (b) paraffin, (c) ceresin, (d) beeswax _____

9. What is amelogenesis? _____

10. In teeth with hereditary opalescent dentine there is a (a) high, (b) medium, (c) low, caries susceptibility _____

FOR CORRECT ANSWERS SEE PAGE 1282

The Argument *Against* Fluoridating City Water



BY GEORGE A. SWENDIMAN, D.D.S.

LONG AGO the philosopher Publius wisely pointed out: "There are some remedies worse than the disease."

Today, after four or five years of somewhat superficial, pseudo-scientific experimentation, dental associations strongly advocate the fluoridation of city water. We may well inquire as to whether any possible good effects of fluorine upon the teeth of our citizenry may not be outweighed by attendant "ills we know not of," whether, in short, our remedy may not be worse than our disease.

Let it be known at the outset that I am heartily in favor of any plan that will reduce dental caries and will, at the same time, improve the overall health of everyone. But I maintain that the long-term effects of fluorine in varying amounts upon the bones and vital organs of the human body have not been ascertained. Our information about fluorides is partial and incidental. We do know, for instance, that the fluorides are extremely corrosive and are used in etching glass. Fluorides also are used as a highly potent rat poison. Now these last uses may sound like splendid qualifications for a regular addition to our diet in the view of the dental association, but may I be pardoned for suspending judgment. I do not crave rat poison, even well diluted. How do I know this poison will not have a cumulative effect? Suppose this diluted rat poison gradually ruins my kidneys and thus sends me to my grave? Will it be any comfort

to me if my dental association says, "He died with perfect teeth"? As an American citizen, I crave to be treated neither as a rat nor as a guinea pig.

An excess of fluorides in drinking water has mottled the teeth in various American communities. Who will guarantee that if fluoride is diluted one part to a million of water, as advocated by Public Health officials, that it may not have some prolonged, insidious effect?

I have always urged that dentists consider their patients' general health as well as the conditions of their teeth. This advice applies particularly with respect to the fluorides. Operation Dental Caries may prove a success but Operation Vital Organs may be be a failure.

Condemns Synthetic Foods

In my opinion, the dental association proposes to treat an effect rather than to eliminate a cause. The prime causes of tooth decay, as every dentist knows, are candy, soft drinks, and refined foods. A courageous association would attack the consumption of these health-destroying foods, not just experiment with medicines to treat a symptom. Unfortunately, wealthy and powerful interests are engaged in the manufacture and sale of sweet, nutritionless foods. To attack these mighty interests requires idealism, imagination, integrity. Do our dental associations qualify?

As long as we are hanging out dirty linen, may I point out another fundamental inconsistency in the ideology of our associations? As a professional group, we have hitherto opposed socialistic practice in all its forms. Have we not fought socialized dentistry? Have we not objected strenuously to compulsory health insurance? Have we not denounced every effort that would compel the layman to accept volume dentistry and to submit to the service of a dentist whom he may not choose? Yet now we are sponsoring a program that will necessarily compel everyone from infant to grandfather to drink fluoridated water whether he wants it or not, whether it jeopardizes his life or not.

The fluorides are an experimental type of medicine. If a man individually, or at the behest of his family physician, decides that fluorides are for him—fine. Independent concerns can be found to supply fluoridated water to independent consumers, just as they now supply spring water in most cities. If the demand is there, the supply will be there. And the whole process will take place in the American way. Meanwhile, when I contract for water, I want water;

I don't want any socialistic bureau to decide that some dubious medicine must be forced down my throat at the same time. If I shut my eyes to the fluorides this time, then next spring the social planners may decide that sulfur and molasses is good for most people, and I'll be forced to drink that in the city water, too.

Government Intervention

I say that fluoridation of city water is a subtle way to promote socialized dentistry. Many children who drink fluoridated water will continue to have caries, and their mothers will clamor for increasing degrees of government intervention. If the government is given further responsibility in prescribing for public health, that responsibility can lead to only one thing—yes, to socialized medicine. It is an axiom in our government that bureaus always expand; they never contract.

It is well known that a medicine rarely affects individual people in the same way. What cures one may be harmful for another. "*Quod ali cibus est aliis fiat acre venenum,*" as Lucretius wrote two thousand years ago: What is food to one may be fierce poison to others. Who then should prescribe for a patient? Should it not rightly be the individual dentist or physician? Is he not in the best position to know the physical condition of his patient?

Plainly, we can never fight socialism by fluoridating the city water. A better, more direct method of preventing and reducing dental caries exists. It is a natural way, too, and indisputably will improve the general health of our patients. If the American Dental Association is sincere in its concern about dental caries, if it honestly wishes to reduce the incidence of caries, let it take a tip from the numerous articles in dental journals identifying the causes of this malady peculiar to our civilization. Let it study the eating habits of primitive men. In contrast to "civilized" people, primitive men had splendid teeth, perfectly-formed dental arches, sound bones, and well-formed bodies. Caries of teeth was virtually non-existent. The people ate nutritious natural foods—whole grains, vegetables, fruits, meat, cheese, nuts—because these things were available and they craved them. No juke-box joint stood on the corner to tempt them to buy candy bars and soft drinks. As a result, they prepared properly for parenthood and a vigorous adult life. Mothers had healthy, normal children, easily and naturally. And they suckled their young.

If we are going to compel people to do anything they may not want to do, why not compel them to refrain from consuming candy, cakes, cookies, and soft drinks? Why not prohibit, by suitable laws, the manufacture of refined sugar, refined flour, and

★ ★ ★ ★ ★ ★ ★ ★

ORAL HYGIENE AWARD

This article by GEORGE A. SWENDIMAN, D.D.S., has won the $100 ORAL HYGIENE award for the best feature published this month.

★ ★ ★ ★ ★ ★ ★ ★

similar devitaminized atrocities?

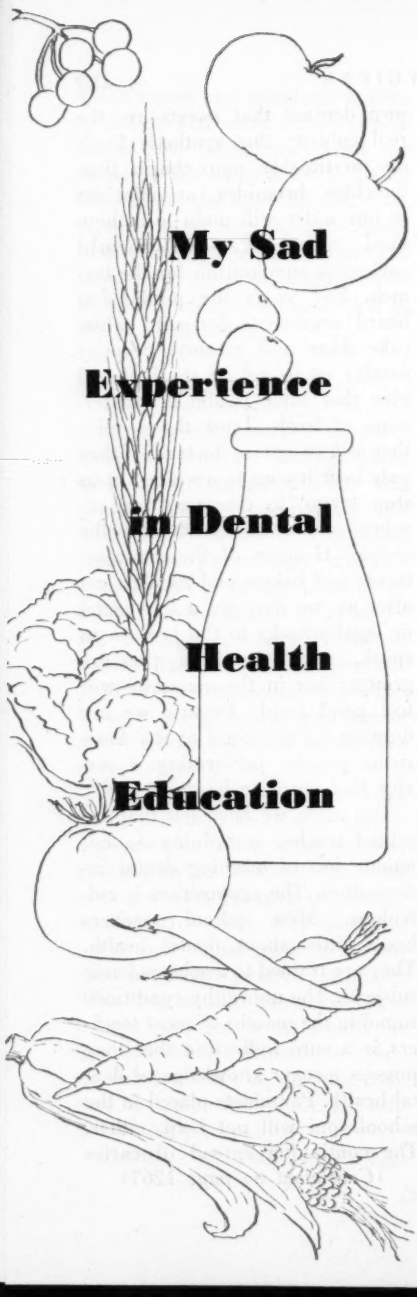
Why has the American Dental Association never inaugurated a crusade against the synthetic, devitalized foods that are undermining the health of our nation? Sure, some say, "It can't be done," or "It's too big a job," or "It will hurt some big business interests." But it *can* be done, if there is a will. It will be a tremendous job; yet our own association should be the spearhead. If we don't start the campaign, who else will? The milling interests? The taffy makers? The soft drink wholesalers? Let's not indulge in wishful thinking.

Nutrition Education Needed

Every dentist realizes that natural, nutritious foods promote good teeth and good health. He knows, too, that an excessive amount of carbohydrates is conducive to extensive caries of the teeth. He gets most of this information from dental journals which are filled to the gills with articles on this subject. Now, may I ask, "What good are these articles if they are not read by the laymen?" Do we have to keep convincing our own dentists that sweets are the real culprit; that synthetic foods do inestimably more harm than fluorides, bromides, or chlorides in our water will undo in a thousand years? No—we should save such ammunition for the laymen. For years the public has heard arguments for soft, white cake flour and creamy, crunchy candy; let us get on the ball and give that same public a counterblast of truth. Trust the people; they will recognize the truth if they only hear it once in a while. Let us stop trying to convince one another and start convincing the people. If some of the manufacturers and bakers and retailers get after us, we may get a few social or legal whacks to the jaw, so to speak, from the irate pressure groups; but in the main, we will feel good inside because we are fighting for the good of the American people, performing a service that needs to be done.

Too often we have felt that the school teacher was doing an adequate job of teaching dental information. The supposition is ridiculous. Most school teachers know little about dental health. They are trained to teach academic subjects. The unhealthy conditions found in the mouths of most *teachers* is a sure indication that they possess meager knowledge of dental health. Pamphlets placed in the schoolroom will not help, either. The continuing spread of caries

(*Continued on page* 1267)



My Sad Experience in Dental Health Education

BY WILLIAM C. POULSON, D.D.S

BEFORE WRITING this article, I should like to pause long enough to take off my hat to Doctor Swendiman in appreciation of his article WHAT IS DENTAL HEALTH ALL ABOUT? published in ORAL HYGIENE.[1] Some fifteen years ago, I was so filled with his views, and the idea of educating the public and my patients, that I could think of nothing else. This was because I had seen so much of the miracle that foods could work upon teeth and health.

For a period of ten years before that I had taken care of the teeth of 250 children in an orphans' home in Bucks County, Pennsylvania. This home was situated on a 200-acre farm where all the vegetables eaten were fresh from the garden. The winter supply was canned immediately after it was taken from the soil. They grew their own wheat which was made into whole wheat bread such as I have not tasted since. It was not reinforced, adulterated, or homogenized. The children had plenty of fruit, whole milk without grades A, B, or C stamped on the containers, and a minimum of sweets.

As these children came to my office in little groups every Friday, an entirely new picture of dentistry began to open before me. I saw

[1]Swendiman, G. A.: What Is Dental Health All About? ORAL HYGIENE 41:360-364 (March) 1951.

Proper nutrition and good teeth are inseparable: a neglected factor in dental education.

little seven-year-olds, whose deciduous teeth and six-year molars had all but broken down before they entered the institution; they were necessarily from poor families. But after a year or less at the home, their teeth no longer caused any trouble. All the cavities were covered with hard secondary dentine. I made no attempt to restore most of them. Under a healthful bodybuilding nutritional regime, Nature had taken care of them in a way that amalgam or cement restorations could never accomplish.

Effect of Diet

There was one group of twenty-one children, ranging in age from 6 to 16 years, who had been in the home from babyhood, and had always enjoyed the benefits of the home food. Among this group of twenty-one, there was not one case of caries! Incidentally, a year after I moved to Philadelphia and had to give up the care of the children, I learned of one who had been adopted by a Philadelphia family. I had Johnny, of my famous twenty-one, around to the house and examined his teeth. He had six cavities.

Filled with enthusiasm, I determined to work on the public schools. The average number of cavities of the home children at that time was one and a fourth per child. The average at the public school clinic in Philadelphia that year was fourteen per child. With the aid of a friend on the school board, we made rounds of the school cafeterias, admired the brilliant array of candies and cakes on the tables, and learned that 140 loaves of refined white bread were consumed daily to one loaf of doubtful whole wheat, and that not over 10 per cent of the 90,000 children drank any milk. When I asked whether the skins of potatoes were cooked with the rest, the nutritionist informed me in a rather surprised tone, "Oh! no, the children would not eat potatoes that were brown."

Finally I put my scheme before the board. I wanted to get a small number, twelve or fifteen, from each class to promise to take for their lunch the food I would prescribe; and, by a frequent check-up, I could convince them of what proper nutrition could do to their teeth. I hoped the results would create some enthusiasm among at least a part of the other students. I was informed, after six months of frequent meetings and arguments, that the board had no money for such a program. They would not object if I wished to undertake it at my own expense.

During this time, the late Doctor Weston Price who, I consider, has shed more light upon nutrition and health than anyone in the

medical or dental profession, came to Philadelphia and I had the pleasure of having lunch with him. He was enthusiastic about the school idea, and promised to analyze the butter that I would use, and to help me in any other way he could. I had to realize later, however, that the whole affair was hopeless. If any results can be hoped for, the school children must be reached and an endeavor made to get as many of them as possible to become more "food conscious." They can have their Gallic Wars translated for them, but they will always have to do their own eating.

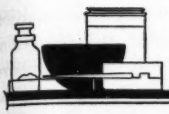
Lack of Interest

In my numerous meetings with other dentists at that time, I found that few of them professed any knowledge of nutrition or showed any interest in the subject. At the Evans Dental Institute of the University of Pennsylvania, I could not find a single senior student who had heard of Doctor Weston Price or of the wonderful things he had done.

I should like to see a television program put on with a convincing talk accompanied by a showing of photographs and roentgenograms of some of my children at the orphan's home, demonstrating the miraculous growth of secondary dentine on their carious teeth under proper nourishment. It could reach both children and adults, even if it had to be accompanied by a "Howdy Doody" program. Perhaps enough dealers in pure foods could be induced to sponsor such a program, or the American Dental Association might lend a hand.

Of course, the health of those children at the home matches the health of their teeth. Although they are not isolated, being sent out to high school, there has not been an epidemic of children's diseases during the last forty years. There have been but three deaths in the home in the last thirty years. It seems a hopeless task to compete with the big food interests with millions of dollars behind them for publicity. And the great public asks only three questions about food—"Does it look good?" "Does it taste good?" and, "Is it easy to prepare?" These questions are easy to answer with the aid of dyes, sugar, and modern ingenuity. Our medical and dental professions are skillfully trained to take care of all the diseases that occur in the human body, even cure some of them. And it is big business—somewhat like training a large group of termite experts to load building foundations with termites and, at the same time, train another group to exterminate the termites before the foundations are ruined completely.

856 *North 21st Street*
Philadelphia, Pennsylvania



TECHNIQUE of the Month

Conducted by W. EARLE CRAIG, D.D.S.

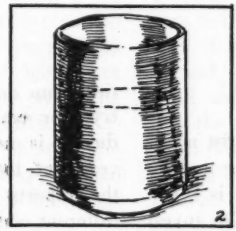
Drawings by Dorothy Sterling

Measurement With Copper Band Instead of Wire for Crown Bands

By WILLIAM FINE

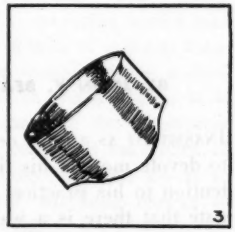
1

Prepare the tooth in the usual manner for a hollow metal crown.



2

Select a stock copper band that fits the preparation accurately.



3

Shape the band to the gingival contour.

4

Cut off the top half of the band. Check the fit of the band on the prepared tooth.

5

Slit the band and flatten it out to take the measure for the crown band.

We invite dentists to submit material for this page. $10.00 will be paid for each technique used. Send your technique to:

Dr. W. Earle Craig,
Oral Hygiene
Publications,
1005 Liberty Avenue,
Pittsburgh, Penna.

How To Be Free of Investment Details

BY JOHN Y. BEATY*

INASMUCH AS a busy dentist needs to devote most of his time and attention to his practice, it is fortunate that there is a way to invest surplus funds and have those investments supervised by experts at little cost. The method is to buy shares in an investment trust.

The investment trust is a mutual organization in which thousands of investors have placed their surplus funds. A number of experts are employed to supervise the daily investment of the funds.

The common method of selecting investments is to buy stocks or bonds representing income from many different industries or from many different companies. Some investment trusts buy securities from only one type of industry. For example, the chemical industry is represented by one investment trust but, in this case, the experts select securities from different companies in many parts of the country, all engaged in the production of various chemicals. Thus, diversification is assured. As a matter of fact, the basic reason for investment trusts is to provide diversification for investors in a more thorough way than any one investor could provide for himself.

Generally, the income from the shares of an investment trust is larger than might commonly be obtained by an individual investor. For example, specialty funds, such as one investing only in the chemical industry, have produced incomes of all the way from 3 per

*Editor of *Investor's Future.*

cent to 8.6 per cent in a single year. On the other hand, income from what is known as balanced funds—that is, those investing in several different types of business—have produced incomes all the way from 3.8 per cent to 6.5 per cent. The average income from six balanced funds was 4.9 per cent, whereas the average income from eight specialty funds was 5.6 per cent. This is the amount received by the stockholder after the expense of managing the fund has been deducted.

The method of placing your surplus funds in an investment trust is simple. You merely buy a certain number of shares of stock in the trust at the prevailing price. After that, you have no further supervision except to re-invest the income which is received regularly in the form of dividends.

Earn Capital Gains

In the meantime, however, the managers of the trust watch the daily market with an experienced eye and make changes in the holdings of the trust according to the best interest of the stockholders. For example, there may be a time when it is advantageous to sell certain stocks or bonds and buy others in their place with the result of getting higher returns. With such a large fund as is represented by any of the well-known investment trusts, it is comparatively easy for the managers to obtain capital gains as well as dividends and interest. A capital gain is obtained when a stock purchased at a low price is later sold at a high price.

Investment trusts provide expert security buying for busy dentists.

As the assets of the investment trust change according to the judgment of the management, there is nothing at all for the dentist shareholder to do. The net result is exactly the same as if you bought shares in the General Electric Company. The managers of the corporation would take care of all details of making money and you would receive a dividend check at stated times. It is just the same with the investment trust. The managers take care of all the details. All you do is to receive your dividend checks at stated intervals.

It is easy to see that investment in this type of stock keeps you free from market worries; regardless of whether the stock market goes up or down, you have no concern as to what is being done with your funds. They are being managed by experts. If you were to manage your own funds, you would be concerned with the change in the market prices and also with continuous diversification. Diversification is systematic and professional when provided by the investment trust.

Another feature which all dentists appreciate is that the shares

of investment trusts are readily saleable. Many companies guarantee to buy the stock back from you at any time you wish to sell at the prevailing price. If you would enjoy having your funds in a specialty trust made up of securities issued by types of companies with which you are familiar, probably you can find the fund you need. On the other hand, if you prefer to have money invested in a variety of businesses, then one of the general funds can be selected.

Trust Information

If you live in a city where there are large banks, you can have access to a book describing all of the existing investment trust companies. In this book you will find complete information about each company. Either the investment department of the bank or the trust department has this book available and will make no charge for your reference to it. It might be a good idea while you are in the bank to ask specific questions of the trust officer or the investment officer. If your practice is in a smaller place where the bank does not have the book, INVESTMENT TRUST COMPANIES, your banker can still be of help to you by getting information from his city correspondent bank regarding any trust fund, or any type of fund, which interests you.

For example, if you would like to have complete information about funds specializing in the chemical industry, tell your banker and he will get information on the companies in that category. If there is any doubt as to the success of a new fund, the investment officer in the city bank will undoubtedly know about it and will advise you accordingly. The older companies have proved their abilities, but there might be a reason for choosing one instead of another and the investment officer in the city bank will know of these reasons.

The investment trust is an old form of investment protection and has three objectives in general. The first is to protect the capital of the investor; the second is to increase the value of his capital by making capital gains through buying and selling; and the third is to provide a regular income. While this income may not be exactly the same each year, it is regular.

To give you an idea as to the number of investors who have found investment trust shares a good way to rid themselves of investment details, the number of shareholders increased in a recent nine-year period from 296,056 to 842,198.

If you study the book, INVESTMENT TRUST COMPANIES, you will see the percentage of income paid by the different funds. *Specialty funds* in a recent year, for example, in eight different lines, had the following percentages of income which were paid to invest-

ors: 4.2, 3.0, 5.1, 8.1, 7.2, 2.9, and 8.6 per cent.

Income from six of the *balanced funds* is represented by the following percentages: 4.6, 5.1, 4.0, 6.5, 5.8, and 3.8 per cent.

It is evident that the income of 8.6 per cent on a specialty fund was the result of capital gains in the fund during the year when that amount of dividend was paid. In other words, some stock was sold at a higher price than its original purchase price and this capital gain made it possible to pay a higher rate to stockholders of the fund.

There are some trust funds which specialize in bonds only. These generally have a lower rate of return than those which invest in common stocks. There are others which specialize in preferred stocks, some only in common stocks, and some in all types of securities.

Without a doubt, a busy dentist can benefit from talking with his local banker about investment trust funds. However, there are some who prefer to study investments and reach their own conclusions as to what to buy and what to sell. For those, help will be given in future articles in this series.

Wee Thistlebrae Farm
Crystal Lake, Illinois

THE ARGUMENT AGAINST FLUORIDATING CITY WATER

(*Continued from page* 1259)

among school children indicates that this method has made no appreciable improvement.

One thing will help. We, the members of the American Dental Association, can strike at the very roots of the problem. We can start treating causes, not effects. We can campaign for better systemic health through natural, nutritious foods. Perhaps the American Medical Association will combine with us in the campaign—it is as much their problem as it is our problem. But ultimately, of course, the whole thing is an American problem and all civic and national associations which are welfare-minded will cooperate. Still, let us not be too concerned with who will join us and who will not. Our mission is an excellent one—that is what matters. We see our duty and, if we are to preserve a clear conscience, we will perform it.

First National Bank Building
Grand Forks, North Dakota

As she enters the dental office, a patient is greeted by Doctor J. D. Walsh from the window of his operating room.

Outdoor Reception Room

BY ANNE O'BRIEN

"WE SHOULD have thought of decorating and using our yard years ago. Since we have put it to use, our summers are so much improved."

The quote is from Doctor John J. Clark, who started practicing dentistry forty-six years ago in New York City's Chelsea district. In 1925, with his three brothers (one a physician, the others dentists), he bought the brownstone house at 313 West 14th Street for offices and residence. Doctor James still occupies the medical suite. Doctor John practices with his nephew, Doctor J. Donald Walsh, Doctor Albert Wuthenow, and dental hygienist Noreen Clark, in the dental extension.

Garden and patio in heart of Manhattan provide pleasant relief for dental patients.

Until three years ago, the dental offices overlooked a typical drab city yard—about 1000 wasted square feet. Now, at no great expense, this area is transformed into a pleasant garden reception room and is a means of overcoming many irritations which, during the summer, must annoy any dentist who practices in a busy, crowded city.

Chelsea is one of New York's oldest and busiest areas—a district of strong contrasts, on the rim of Greenwich Village. To some it is a romantic and historic section, yet it is a place of clangor and crowds, and oven-hot in summer.

Other city dentists will appreciate what it means to have a cool, grassy garden available for the use of patients. This outdoor reception room is behind the buildings, protected from noise, dust, and hot concrete. The idea developed by chance during the remodeling of the front of this 106-year-old brownstone house. While men and tools were available, it seemed the time to make minor repairs on the

The appeal of this cool, sheltered patio and the pleasant garden brings patients in early for their appointments.

back yard. To control dust from patchy soil, paved sections were enlarged. Narrow blue-slate walks were torn up, and the slate re-used to form the floors of fourteen-foot flagstone patios. The old lateral board fence was replaced with an attractive cedar stockade fence which is less expensive and requires no upkeep other than varnishing twice a year. The patients were "sidewalk superintendents" and, at their suggestion, flower boxes were built to surround the yard. A shade area was provided by erecting a sturdy shed over one of the flagged areas.

Patients Bring Flowers

By this time, the office force was doing porter duty carrying chairs for patients who went outside to check developments and lingered there, enjoying the novelty of their surroundings. More than one joked, "Oh, ask Doc to forget the dentistry and spend my appointment out here relaxing." So, the next improvement was a set of comfortable outdoor peel furniture. Soon, it became customary for patients to say, "I'm a little early —call me when Doctor's ready; I'll be outdoors."

There are many gardening discussions as flower hobbyists spot each other in the outdoor reception room, and they offer some good advice. Suburbanites bring seedlings from their own gardens and keep a possessive eye on their progress. Now the flower area has outgrown the border boxes and overflowed into the lawn area.

New patients claim it was this unique reception room that attracted them to "313." Young mothers, who must bring their children along, say that, if it were not for the convenience of leaving their youngsters out-of-doors, they would have to postpone their own dental treatment until fall. Children enjoy the outdoor freedom and, as patients, are not the problem they would be ordinarily.

The expenditure in cash and effort for the outdoor reception room was small and the staff, as well as the patients, have derived inestimable pleasure from this garden that "grew by accident" in the center of the city. Now, we are busier, yet less fatigued, than in pre-garden summers. Tempers are cooler and relationships are more cordial.

313 *West 14th Street*
New York 14, *New York*

WHEN YOU CHANGE YOUR ADDRESS

WHEN YOU change your address, please always furnish your old address as well as the new one. If your post office has zoned your city, the zone number should be included. Please send address change promptly to ORAL HYGIENE, 1005 Liberty Avenue, Pittsburgh 22, Pennsylvania.

Dentists in the NEWS

Philadelphia (Pennsylvania) Evening Bulletin: Doctor Lester W. Burket has been appointed dean of the University of Pennsylvania School of Dentistry, according to an announcement by Harold E. Stassen, university president. Associated with the School of Dentistry since 1937, Doctor Burket has been professor of oral medicine and chairman of the Department of Oral Medicine. He succeeds Doctor Joseph L. T. Appleton, who asked to be relieved in order to devote his entire time to research and teaching.

Welch (West Virginia) Daily News: To Doctor E. E. Hale, a Coalwood dentist, and his partner, Wally Greer, goes the distinction of being the first to contribute chinchillas to be used as "guinea pigs" in disease research, according to the McDowell Medical Society. The two operate a chinchilla farm near New Market, and have donated twenty chinchillas to the University of Miami where extensive cancer research is being conducted.

Another first for Doctor Hale, a member of the famed Explorer's Club, was a descent of 634 feet he made with Doctor J. E. La Barre down a mine shaft near Caretta, seated in a 14-foot long, double-deck steel tube which was lowered by a rubber-tired mobile crane. The occasion was the dedication of a unique emergency escape hole planned by the mine operators to provide an exit for approximately 100 men who work in the area.

The Redwood Falls (Minnesota) Gazette: Twenty years from now, people gazing at the bright fall colors of the hard maple trees in Ramsey State Park in southwestern Minnesota will be indebted to a Redwood Falls dentist. Doctor C. L. Lynn together with Doctor W. A. Brand, has planted more than seventy-five hard maple trees in the park, most of them marked with bright plastic bands for identification in future years.

Doctor Lynn's plan is to have people "adopt" pieces of land in the park and see that several hard maple trees are planted on each and assure their healthy growth. He thinks there is room for 50,000 maples among the hundreds of thousands of trees already there. The park, Doctor Lynn believes, is a natural habitat for this tree.

New York (New York) Times: As disclosed by Doctor Marcus Kogel, New York City Commissioner of Hospitals, Yeshiva University in the Bronx has been granted a charter to operate a medical and dental school. With permission of the city, the university will erect its $25,000,000 medical center to be affiliated with the Bronx Municipal General Hospital, a $36,500,000 unit now under construction. The center will comprise twelve buildings, housing basic science, library, administration, laboratories, auditorium, medical and dental students' residence, school of dentistry, school of nursing, nurses' residence, utilities, general hospital, future school of public health, and future research laboratories.

The new Yeshiva Medical School will be ready to open in the fall of 1953, according to present plans, and will provide for 400 students each in the dental and medical branches.

Flat River (Missouri) Lead Belt News: A hundred Flat River citizens recently joined in a testimonial dinner to honor Doctor Edward Griffin, who celebrated his fiftieth anniversary as a dentist in the community. Choosing dentistry over farming with his father in Sainte Genevieve County, Missouri, Edward Griffin enrolled in the School of Dentistry at Washington University, St. Louis, in the fall of 1898. On May 17, 1901, he opened his office in Flat River where he has taken an active part in civic, professional, and church organizations ever since. Doctor Griffin makes no mention of retirement, but he does plan to take a little more time for recreation, which, in his case, will be his favorite sport, fishing.

Syracuse (New York) Post-Standard: At the Tri-City Rose Festival held in Newark, New Jersey, a white rose, the "Rex Harrison," entered by Doctor Michael Leo, won top honors as queen of the show. In addition, the Syracuse dentist won two first ribbons, two second ribbons, and a third ribbon out of his ten entries.

St. Louis (Missouri) Globe-Democrat: Three years ago his enthusiasm for outboard motor-boat racing cost Doctor Barnes Souder, St. Louis dentist, his left arm in a racing mishap at Hardin, Illinois. As a result, he resigned himself to the fact that any further dentistry in his career would have to be in the form of teaching or laboratory work. However, after about six months, he returned to his office and one effort led to another until gradually he realized he could do just about as much with one arm as he could with two.

Now, determined to re-establish his practice, Doctor Souder has developed a revolving vise for one-handed denture-making. The difficulty of drilling with only one hand is solved by the use of the Airdent machine, and the fact that he was ambidextrous has eased the problem of adjustment in general. With these aids and the help of his assistant, Jeannette Bechtel, the hardy dentist has built his practice back to 60 per cent of what it used to be.

Taking his handicap in his stride, Doctor Souder hopes to devote his time exclusively to prosthetics one of these days. Until that time comes, he will be busy welcoming the return of former patients and coping with the problem of tying his own shoelaces.

Philadelphia (Pennsylvania) Inquirer: Doctor Martin A. Haurin of 3452 Englewood Street in Mayfair, has a versatile ground floor in his home. It houses a dental office, laboratory which doubles as darkroom and jewelry workshop, a machine shop, and a boatyard. Here, in addition to the details of his dental practice, the 37-year-old dentist builds boats in his spare time. His first boat, the Gooch I, broke two national records and inspired him to design a hydroplane. With a friend, George Kueny, he made the hydroplane, Gooch II, on the three-point suspension theory. "We never broke any national records in her," he said, "but we did win the unlimited speedboat championship of the Delaware in 1947."

Indianapolis (Indiana) Star: Bouba, one of the San Diego Zoo's three young gorillas, survived a successful dental operation when she had two broken teeth removed. She was given an anesthetic, and the teeth were extracted by Doctor Q. M. Stephen-Hassard of La Jolla. How Bouba broke her teeth is a mystery.

Battle Creek (Michigan) Enquirer and News: At a banquet in the Hart Hotel in Battle Creek, Doctor Edmund D. Vince and Doctor Adalbert A. Welch were honored on their completion of fifty years in dentistry. Over sixty guests, including Doctor F. B. Vedder of the

University of Michigan Dental College and Doctor A. Raymond Barault, Jr., Dean of Dentistry at Loyola University, Chicago, attended the dinner given by the Battle Creek Dental Society. Elaborate souvenir albums containing candid pictures taken during the evening, transcripts of the speeches, signatures of guests, and congratulatory messages from out of town, were prepared and given to the guests of honor.

Chicago (Illinois) Tribune: At a recent Zonta International convention held at the Stevens Hotel in Chicago, the question was asked, "Do women have an equal chance with men to succeed in the business world?" Doctor Angela Moriarity, Annapolis, Maryland, dentist, believes the opportunities are quite unbalanced. Said Doctor Moriarity, " . . . in the healing profession the women are definitely discriminated against. You can be a poor dentist as a man and make a living; but, as a woman, you have to be better than good. There is a certain class of people who do not respect women as doctors."

Awards for items published in this month's DENTISTS IN THE NEWS have been sent to:

Thelma Mae Lane, Esther, Missouri.
Joseph F. Lush, Jr., D.D.S., Indianapolis General Hospital, Indianapolis 7, Indiana.
Lee Alaman, 705 North 63rd Street, Philadelphia 31, Pennsylvania.
Mrs. Enoch Sundberg, 543 West Michigan Avenue, Battle Creek, Michigan.
William J. Von Bank, D.D.S., New Ulm, Minnesota.
Nancy Herring, 449 Lafayette Street, Jackson, Tennessee.
Theodore Katz, D.D.S., 2802 Grand Concourse, Bronx 58, New York.
William Perry, D.D.S., 301 South 15th Street, Philadelphia 2, Pennsylvania.
Dorothy M. Donnelly, 532 North Salina Street, Syracuse, New York.
Jean Nester, Box 585, Coalwood, West Virginia.

CAN YOU USE A DOLLAR?

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EDITORIAL COMMENT

"Give me the liberty to know, to utter, and to argue freely according to my conscience above all liberties." *John Milton*

UNIONIZING THE DENTAL LABORATORIES

EVERY FEW years a movement gets under way in some part of the country to unionize dental laboratory technicians. The argument is given that the technician must be protected from the avarice of the laboratory operator and, unless hours and conditions of labor are controlled, the technician will become the economic slave of the laboratory owner. In an industry where the average employment in each laboratory is less than four persons, including the owner, this argument of serfdom is absurd. In most cases, the owner works longer hours than the employees and under exactly the same working conditions. Except in a few of the larger laboratories, there is no executive or management group for labor organizers to rail against.

In Chicago, there are 250 dental laboratories. Only 6 of these 250 employ 25 or more technicians. The total working population of these laboratories is less than 900 persons, or an average of less than 4 persons each, including the owner. This would not appear to be a lucrative field for union organizers.

No one who is familiar with the industrial history of the United States is unaware of the robber barons and the soulless capitalists who made men work 72 or more hours a week from dawn until dark under unhygienic conditions without paid vacations, sickness benefits, or retirement plans. Labor unions came into being to correct these abuses; like other social reforms, they have frequently overextended themselves. Unions are now in many cases the tyrants and management the vassal.

The unionization of the dental laboratory is an affair of concern to the dental profession and to the public because unionization will certainly mean an increase in the cost of laboratory service. The increased cost to the dentist will be passed along to the public. But of equal concern are the possible restrictive clauses that will decree the conditions under which services are to be performed. Emergency work, such as denture repairs, will probably carry a regulation that will result in in-

convenience to the patient and the dentist. Limitation of production will, without doubt, be ordered to protect the lazy and inefficient worker at the expense of the more skillful. Union rules apply a common denominator to producers and so discourage the development of special skills. By so doing, the heart of the true craftsman is hardened and he is relegated to mediocrity and disillusionment. The unrest among many fine craftsmen in all trades may be traced to the restrictive clauses under which they are required to work. Self-expression and pride in craftsmanship are denied them.

Fortunately, all dentists have received basic training in laboratory procedure. We have all been required to process dentures, make castings, fabricate jacket crowns, and perform all phases of laboratory work. We are not, therefore, strictly dependent on the commercial dental laboratory, nor are we at the mercy of the union organizer. The laboratory is a convenience and certainly performs a valuable service—a service that none of us would like to see curtailed. We all have, however, office laboratories that could be expanded and in cases of necessity we could do all forms of laboratory work. Some of us are rusty on the procedures and not particularly disposed to return to the plaster trail or the rouge road. We would prefer to see the survival of the commercial dental laboratory but, in case of excessive price demands or intolerable service conditions, we are able to carry on.

There has been some talk among dentists of organizing cooperative laboratories owned and controlled by dentists and dental societies. These would be similar to farm cooperatives or those organized by labor unions where groups of consumers organize to buy, process, or distribute goods and services to the economic advantage of the consumer. A strong case might be made with the federal government to protect such cooperatives organized for the public health and welfare.

Workers have an exact legal right to join unions if they so desire. No one denies them that right. Dentists have the legal right to perform their own laboratory service if they so desire and they cannot, at the present at least, be restrained from doing so.

Edward J. Ryan

Q ASK Oral Hygiene A

Please communicate directly with the department Editors, V. Clyde Smedley, D.D.S., and George R. Warner, M.D., D.D.S., 1206 Republic Building, Denver, Colorado, enclosing postage for a personal reply.

Hypertrophic Gingivitis

Q.—A young man patient is being given some anticonvulsive drug, probably diphenylhydantoin sodium by his physician and has hypertrophy of the upper anterior gingivae. His mother asks if I know of any treatment for this, but I do not. I told her that gentle finger massage with a mild tooth paste would probably be the best thing and that, if the condition did not exist prior to the taking of the drug, it would cease shortly after the drug is discontinued.

I should be pleased to know of anything I could do for this case.—E.F.H., South Dakota.

A.—You have advised good home treatment for dilantin sodium hypertrophic gingivitis. In addition, the tooth brushing shou'd be rather vigorous and, inasmuch as the hypertrophy makes deep gingival crevices which are difficult to keep clean, frequent prophylaxis treatments at your hands are indicated. In fact, some writers advise that frequent prophylactic treatments are the best treatment. One of my correspondents wrote me that he had good results in the application of zinc chloride to the hypertrophied tissue. One could safely use a 20 per cent solution.—GEORGE R. WARNER.

Root Canal Therapy

Q.—Is there a routine treatment for infected root canals, using penicillin? If so, could you tell me where to find it? What do you consider the best method of preparing a root canal for restoration?—R.R.C., Kansas.

A.—Let me answer your last question first and deal with the mechanical preparation of a root canal for restoration. All organic tissue should be removed carefully, and in doing this as well as later treatment of the canal, care should be exercised to avoid allowing an instrument to pass beyond the apex of the root.

The surface of a root canal is transversely ribbed or corrugated. To achieve a good result in the final filling of the canal, one must file the walls of the canal until the corrugations are eliminated and the canal perfectly smooth. This is accomplished by the use of successively larger diameter files.

The answer to your first question is, "yes." Grossman,[1] one of our best authorities on root canal therapy, has done a good deal of work with penicillin in this field.—GEORGE R. WARNER.

Dentures and Breathing

Q.—A patient for whom I made a full upper and lower denture several

[1]Grossman, L. I.: Treatment of Infected Pulpless Teeth with Penicillin. JADA **37**:141 (August) 1948

months ago complained recently that he finds it difficult to breathe through his nose when both dentures are in place. He can breathe normally if only one denture, either upper or lower, is in place. This is the first time I have encountered this difficulty and I can find no reason for it. Neither of the dentures is overextended and he does not gag with them.

His physician dismissed him with a cursory examination suggesting a dental examination, but this has me baffled.

May I have your opinion in the matter?—J.E.R., New York.

A.—I have never known of such a case and I can think of no logical explanation for the condition. It certainly seems to be just a notion, but perhaps it would be better to describe it to him as a psychosomatic condition. Assuredly it is nothing for which you should be held responsible. Since it does not occur when either denture is out, you might suggest that the teeth on one or both dentures be reset or that an entirely new set with a more closed bite be made, if he is willing to pay for some experimentation.—V. CLYDE SMEDLEY.

Eroded Incisors

Q.—I have a woman patient of 30 whose two upper central incisors are eroded and pitted as if etched with acid. Her other teeth are perfect with no sign of erosion or pitting of the enamel surfaces. She is a clerical worker and drinks fruit juices, mostly tomato juice.

What caused these two particular teeth to show loss of enamel and pitting while the others are perfect? This situation has come about in the last six months. I am puzzled as to this and would appreciate any enlightenment you can give.—F.J.T., Massachusetts.

A.—Without seeing your case of the eroded and pitted maxillary central incisors, I am at a loss to account for the condition. Are these two teeth positioned more labially than the other anterior teeth? If they are and the patient uses a rather abrasive dentifrice, they would be the ones most likely to suffer. You have rightly considered the possibility of their being affected by fruit acids but I have never seen erosion of teeth from the use of tomato juice and I assume that she is not one who drinks diluted lemon juice for its medicinal properties. But even if she does drink lemon juice or suck oranges, it is not likely that only two teeth would be eroded.—GEORGE R. WARNER.

Bruxism

Q.—I have a patient for whom I have recently made a full upper and partial lower denture. This patient grinds his teeth to the extent of annoying members of his family and acquaintances. Could you suggest anything I might do to assist him in stopping this? Both dentures appear to fit well.—N.H.M., New York.

A.—Doctor Warner has turned your question over to me for reply since it comes more logically under my specialty. If you will, by selective grinding, eliminate the interfering cusps or inclined planes upon which he grinds, this should help him to break himself of this bad habit. I find disclosing wax a

fine aid in accomplishing this task efficiently. I would suggest that you follow the directions that accompany the wax.—V. CLYDE SMEDLEY.

Habitual Aphthae

Q.—I should like to have some advice as to the method of treatment for this patient who came to my office three days ago complaining of ulcers in his mouth.

The patient, a man of 32, apparently in good physical and mental health, has been bothered with these ulcers for the last ten years, and according to his history, he has had just about every type of examination. All treatments (vitamins, cauterization, mouth washes, toothpastes and powders) have offered only temporary relief. However, he has found that when he brushes his teeth with boric acid powder the ulcers decrease, but the boric acid powder now irritates the soft tissues. Also, in his last physical examination, the contents of the stomach were examined and found to be slightly acid.

When I examined him, he had several areas in the mouth with whitish, raised, blister-like spots measuring about ½ cm., but containing no fluid. They had no regular shape but had well-defined reddish borders. They appeared to be what we call aphthous ulcers.

I did not cauterize them or touch them in any way, for they were spread out in several parts of the mouth—inner surface of lip, cheek, hard palate, and tongue. The patient says they appear sometimes in his oropharynx, producing pain when swallowing.

I gave him a prescription for 5 per cent sodium perborate to be used as mouth wash, and gave him another appointment for scaling and cleaning of his teeth and gingivae.

This case does not seem to be a purely local condition of the oral cavity, and I realize it might be difficult for you to suggest diagnosis and treatment. However, any suggestions you can offer will be greatly appreciated.—E.R.F., North Carolina.

A.—The description of the case presented in your letter tallies with that of habitual aphthae, as you suggest, or of the oral lesion of herpes simplex.

According to Prinz and Greenbaum,[2] "The supreme remedy is a very mild caustic applied directly upon the aphtha as soon as possible. An 8 per cent zinc chloride solution, or, still better, a droplet of camphorated phenol carefully placed upon the erosion, twice within a five-minute interval, is usually eminently successful." They also recommend the administration of calcium gluconate (1.5 gm. or about a heaping teaspoonful in a little milk three times a day).

In a recent article in *Modern Medicine* a physician advises the use of pyribenzamine applied directly to the oral lesion of herpes simplex. He says such an application will cause the "disappearance of the lesion within 36 hours as well as give a definite anesthetic effect . . . The 50 mg. pyribenzamine tablet is held in a small forceps and placed in contact with the lesion for 60 to 90 seconds. This application is repeated two or three times daily."—GEORGE R. WARNER.

---

[2]Prinz, Hermann, and Greenbaum, S. S.: Diseases of the Mouth and Their Treatment, Lea & Febiger, 1935, page 178.

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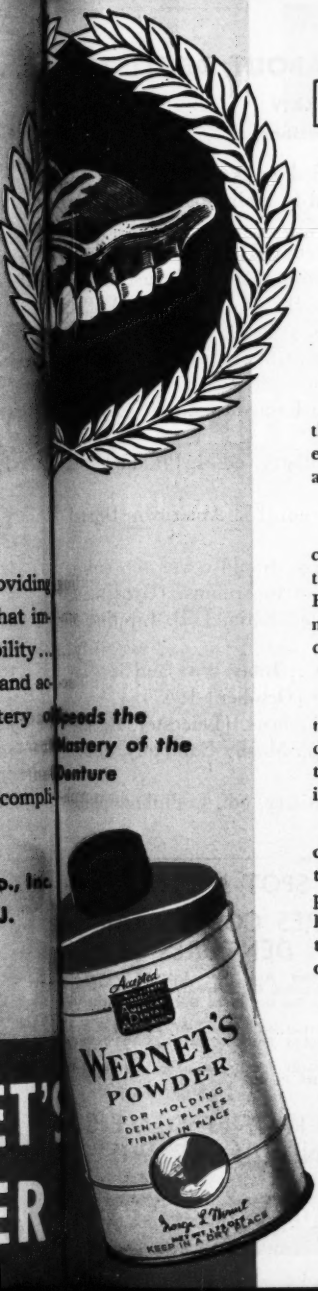

WERNET DENTAL LORE

SEPTEMBER 1951

That the dental profession has especially grave responsibilities in cancer control is reflected by the participation of 38 of the country's dental schools in an active program of cancer education.

• • •

Mother Nature works slowly indeed, at least in the matter of human teeth. The same abnormalities in the structure and position of teeth that we find today were evident at the time of the Neanderthal man, some 50,000 years ago. And to this day there has been no change since that time either in the size of the human jaw or in the number and size of the teeth.

• • •

Archeological finds tell us that the Greeks paid considerable attention to the teeth and mouth, while the Etruscans made great advances in bridgework. But the dentists of ancient Rome improved both, making great strides in dental craftsmanship, especially crown and bridgework.

• • •

The National Security Resources Board reports that by 1954, to meet military and civil defense requirements, the U.S. will need a total of 93,100 dentists, or about 13,000 more than the number practicing today.

• • •

By 1700, a full century before England had a dental school, France had already legalized the position of dental surgeons and dentists, as distinct from physicians and surgeons or barber-surgeons. Dental literature grew so rapidly that between Fauchard's time (1728) and 1839, over 240 excellent French texts on dentistry had been published.

• • •

It is interesting to learn from the Bureau of Labor Statistics that the costs of dental services have been increasing only half as fast as living costs in general.

• • •

In all, there are about 115 species of tropical trees, most of them growing in Asia and Africa, which yield karaya gum, the basic ingredient of Wernet's Powder.

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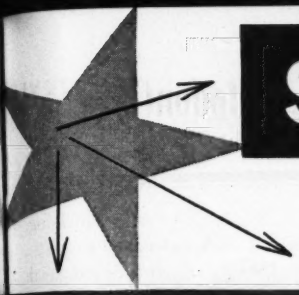
ANSWERS TO QUIZ LXXIV

(See page 1255 for questions)

1. (a), (b)—shrinkage of metal and occluded gases. (Phillips, R. W.: Studies on Density of Castings as Related to their Position in Ring, JADA **35**:329 [September] 1947)
2. Term denoting the removal of partly erupted or unerupted teeth which cannot be extracted by forceps and therefore must be delivered by surgical excision. (Thoma, K. H.: Oral Surgery, Vol. 1, St. Louis, C. V. Mosby Company, 1948, page 226)
3. (a), (b), (c), (d) all. (Mead, S. V.: Oral Surgery, ed. 3, St. Louis, C. V. Mosby Company, 1946, page 117)
4. (a), (b), (c), (d) all. (Accepted Dental Remedies, ed. 15, American Dental Association, 1950, page 41)
5. (b), (c). (McBride, W. C.: Juvenile Dentistry, ed. 4, Philadelphia, Lea & Febiger, 1945, page 220)
6. (a) 2 cc. (Accepted Dental Remedies, ed. 15, American Dental Association, 1950, page 17)
7. The retromolar tubercle—the denture base should cover the entire pear-shaped area to the anterior border of the ramus. (Grossman, L. I.: Handbook of Dental Practice, Philadelphia, J. B. Lippincott Company, 1948, page 380)
8. (a), (b), (c), (d) all. (Washburn, K. G.: Inlay Wax and its Manipulation, Illinois Dent. Journal **16**:410 [October] 1947)
9. Enamel formation carried on by the ameloblasts. (Leicester, H. M.: Biochemistry of the Teeth, St. Louis, C. V. Mosby Company, 1949, page 105)
10. (c) low. (McBride, W. C.: Juvenile Dentistry, ed. 4, Philadelphia, Lea & Febiger, 1945, page 90)



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Laffodontia

Friend: Who established the law of diminishing returns?

John: My laundryman.

★

Boy Friend: I want to do something big and clean before I die.

Girl Friend: Wash an elephant.

★

Wife: The doctor asked to see my tongue. Then he said right away that I needed a stimulant.

Hub: Heavens! I hope he didn't give you a stimulant for your tongue!

Abbie: I don't understand baseball at all, do you?

Joe Lou: You don't have to understand it. Everything is decided by a man they call the "vampire."

★

Bobby: Mamma, what is a 'second-story man"?

Mrs. Bungstarter: Your father is one. If I don't believe his first story he always has another ready.

★

Husband: Just think, a single Mormon would have as many as ten wives.

Wife: My goodness! How many would a married one have?

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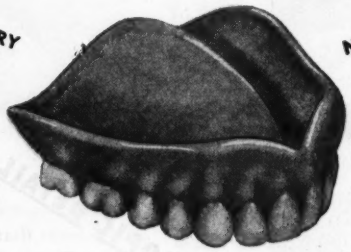

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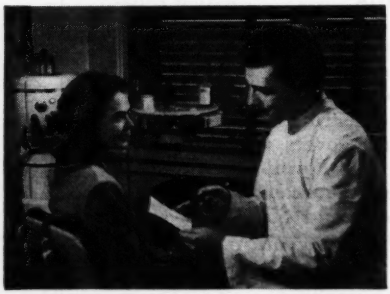

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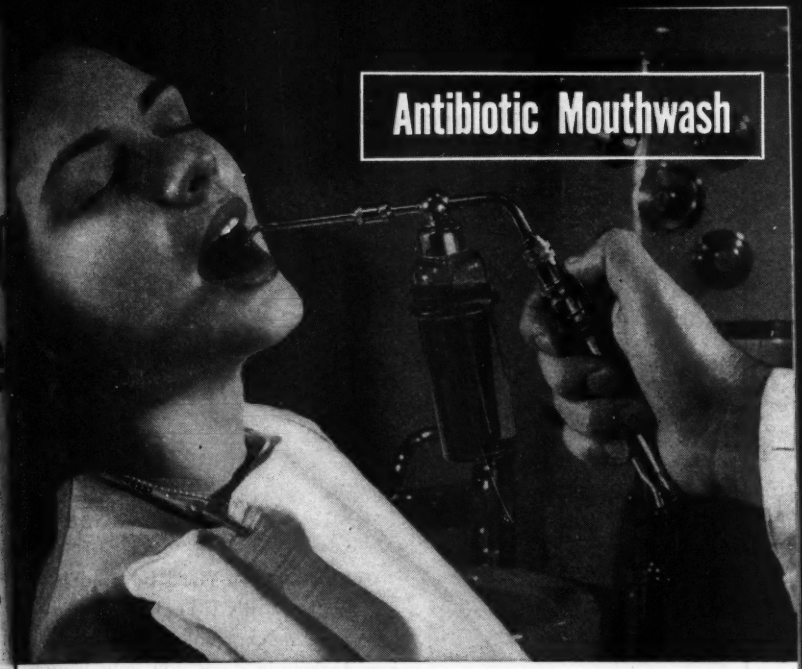

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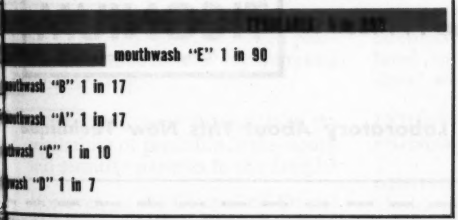

Figure 1. This chart illustrates the exceptionally high bacteriostatic potency of Tyrolaris *in vitro*. Columns graphically represent comparative values for the various mouthwashes—showing how much each can be diluted and yet retain demonstrable bacteriostatic effect.*

**All values represent averages of several tests on* Staphylococcus aureus *at 37°C. Mouthwashes were diluted serially in culture medium and each tube was inoculated with a staphylococcus culture. The end point for each test was the dilution that inhibited growth of the organism at the end of 24 hours.*

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REFERENCES: 1. J. Am. Dent. A. 40:569, 1950. 2. J. Invest. Derm. 14:57, 1950. 3. J. Am. Dent. A. 40:619, 1950.

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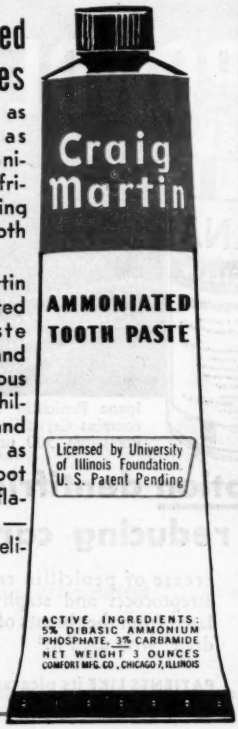

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Why Pay More?

LONG PLAYING RECORDS

(33 1/3 R.P.M.)

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Every Record Guaranteed!

If in New York City visit our stores:

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All in Midtown New York!

For FREE Complete Catalogue and Price List write to:

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520 West 48th St.
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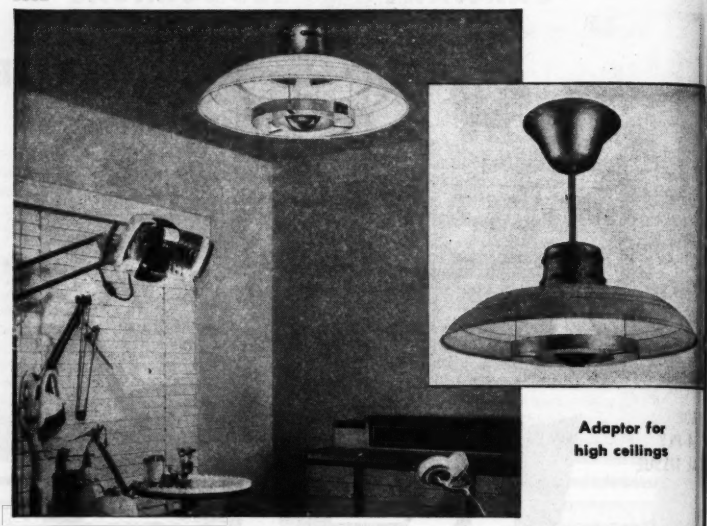
A GOOD STOPPING

Crescent Stopping

- **MADE OF BEST GUTTA PERCH**
- **IS NOT MEDICATED**
- **WILL NOT IRRITATE TISSUE**
- **LEAVES NO TASTE IN MOUTH**

Crescent **DENTAL MFG. CO.**
1839 S. Pulaski Road
Chicago 23, Illinois



Adaptor for high ceilings

Revolutionary New General Vision Light by Castle

The new Castle GV light with the Plexiglass reflector is a new departure in office lighting. Two years of testing have emphasized the advantages this new type of light gives:

- **ILLUMINATES** ceiling as well as floor; you get ⅓ more light because the smooth, translucent reflector sends 85% of the light downward, sends 15% of the light to the ceiling.
- **NO DISCOLORATION** of light because there is no paint pigment in the Plexiglass.
- **NO MAINTENANCE**—on no part is there paint to scratch and chip. The smooth plastic surfaces wipe clean easily.
- **LONG-LASTING**—the plastic reflector and the anodized aluminum suspension rod and louvers are non-corroding lifetime materials.
- **FLEXIBLE**—the GV is adaptable to either high or low ceilings by the use of an inexpensive adaptor. It can be changed from one to the other.
- **SIMPLE INSTALLATION**—your local electrician can install the new GV in a few minutes.

See your Castle dealer or write: Wilmot Castle Co., 1122 University Ave., Rochester 7, N. Y.

Castle LIGHTS AND STERILIZERS

HAVE YOU NOTICED?

HAVE YOU NOTICED how efficiently STIM-U-DENTS clean and polish the enamel while removing food particles from between the teeth and gently massaging the gum tissue?

HAVE YOU NOTICED the healthful glow in the mouths of your patients who use STIM-U-DENTS daily?

HAVE YOU NOTICED that STIM-U-DENTS effectively supplement office treatment and prove an invaluable aid in the treatment of PYORRHEA and GINGIVITIS?

HAVE YOU NOTICED how convenient and pleasant STIM-U-DENTS are to use after meals; that they impart a cleanliness and freshness to the mouth and breath?

AS ONE DENTIST WROTE US: "To me they are the greatest prophylactic or preventive instrument in mouth hygiene yet devised for the use of the patient at home."

Ask for samples for patient distribution.

Use After Eating for Mouth Health. **STIM-U-DENTS** Use After Smoking for Clean Breath.

STIM-U-DENTS, INC., 14035 Woodrow Wilson Ave., Detroit 6, Mich.

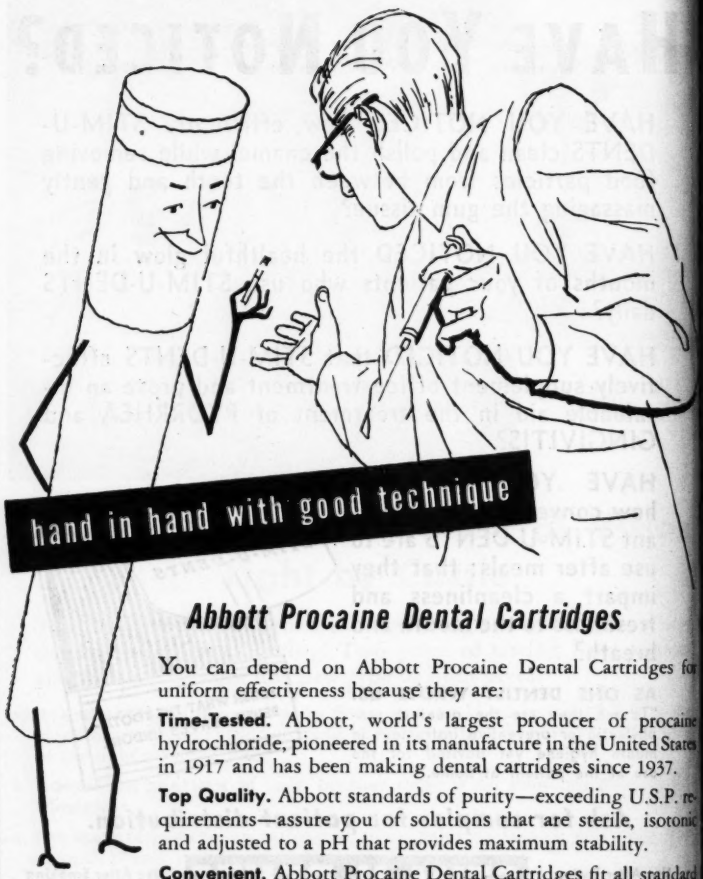
☐ Send FREE SAMPLES for patient distribution. OH-9

Dr._____

Please enclose your Professional Card or Letterhead

Address_____

City_____ Zone_____ State_____



Abbott Procaine Dental Cartridges

You can depend on Abbott Procaine Dental Cartridges for uniform effectiveness because they are:

Time-Tested. Abbott, world's largest producer of procaine hydrochloride, pioneered in its manufacture in the United States in 1917 and has been making dental cartridges since 1937.

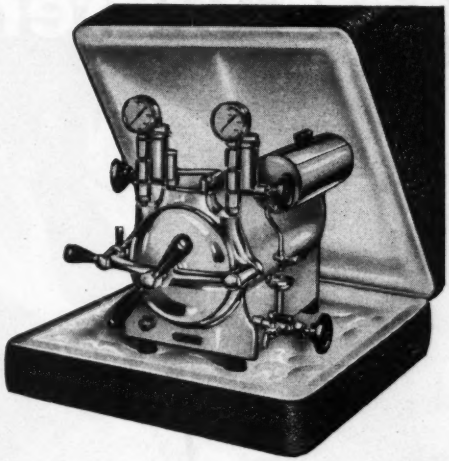
Top Quality. Abbott standards of purity—exceeding U.S.P. requirements—assure you of solutions that are sterile, isotonic and adjusted to a pH that provides maximum stability.

Convenient. Abbott Procaine Dental Cartridges fit all standard dental syringes and are available through your usual source of supply in four commonly-administered concentrations. Won't you specify these effective, time-saving dental cartridges the next time you order procaine? Abbott

ABBOTT'S Procaine hydrochloride

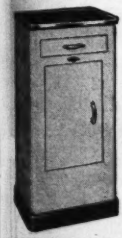
2% with Epinephrine 1:60,000, 1:50,000 and 1:30,000
4% with Epinephrine 1:50,000

The Office Jewel You'll be Proud to Own... with the **SPEED** *and* **SAFETY** *You'll Prize*



NEW PELTON FL-2 AUTOCLAVE

Here is equipment that not only dignifies and decorates the professional office, but, at the same time, dispels fear of post-operative infection. Its 6 by 12-inch pressure chamber offers the ultimate in positive destruction of spore-bearing bacteria. And the FL-2 is as *fast* as it is *safe*. It reduces the time between consecutive sterilizing periods from many minutes to seconds.

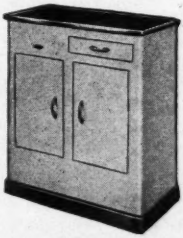


MODEL 70

SPECIAL PELTON CABINETS for FL-2 AUTOCLAVE

These two new Pelton cabinets have been specially designed to accommodate the FL-2. Graceful lines and quality construction are in keeping with the Autoclave's beauty and efficiency.

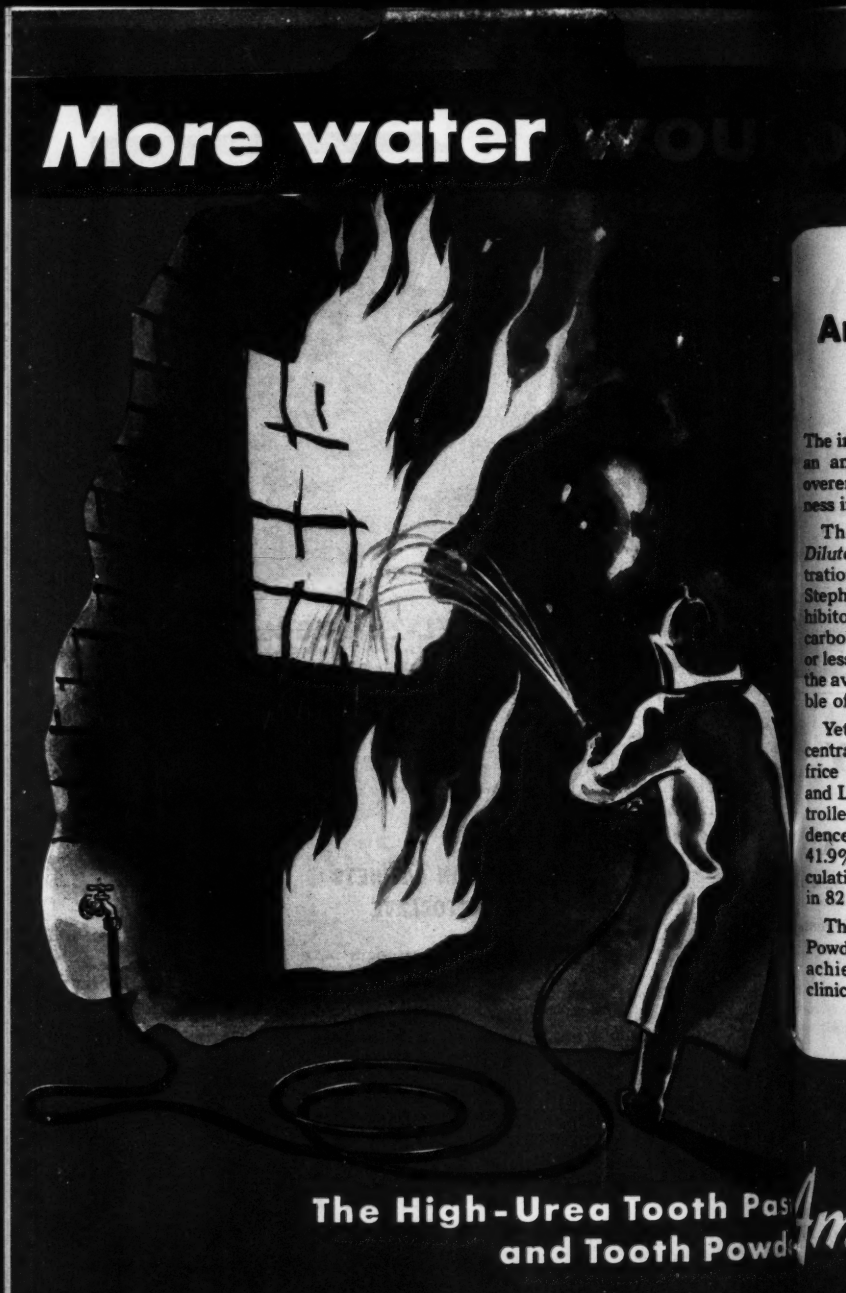
The FL-2 is a long-time investment. You will not regret waiting for delivery.



MODEL 40

PELTON

THE PELTON & CRANE CO., DETROIT 2, MICHIGAN


More water
The High-Urea Tooth Pas
and Tooth Powd

better job...

likewise...a HIGH-UREA Ammoniated Dentifrice can Provide BETTER CARIES CONTROL

The importance of *high-urea* content in an ammoniated dentifrice cannot be overemphasized, if *maximum* effectiveness in caries control is to be achieved.

The reason is readily apparent. *Dilute intraoral solutions*—1% concentration or less—cannot (according to Stephan[4]) exert any appreciable inhibitory effect on acid production from carbohydrates. In 0.5% concentrations or less (according to other authorities[2]), the available urea is completely incapable of inhibiting lactobacilli growth.

Yet, with the *4% intraoral urea* concentration yielded by a *high-urea* dentifrice (Amm-i-dent formula), Henschel and Lieber[1] have demonstrated in controlled clinical tests* that caries incidence was reduced by from 37.5% to 41.9% (depending on method of calculation used). Reduction was shown in 82% of the patients tested.

This high efficacy of Amm-i-dent Powder and Amm-i-dent Paste is achieved with entire safety... clinical tests and gingival biopsies[3] have demonstrated dependable freedom from toxic or other adverse reactions. Complete stability is also assured ... ammonia-releasing properties are maintained indefinitely under normal conditions.

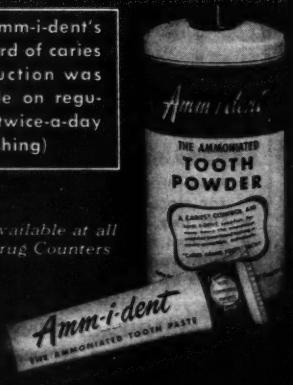
Amm-i-dent Paste or Powder—cleans and polishes thoroughly, and has an excellent flavor.

Professional preference is indicated by the fact that *more dentists recommend Amm-i-dent than any other dentifrice!*

REFERENCES: 1. Henschel, C. J. and Lieber, L.: J. Dent. Research, 28:248, 1949. 2. Kircheimer, W. F. and Douglas, H. C.: J. Dent. Research, 29:320, 1950. 3. Lefkowitz, W. and Tanchester, D.: N. Y. Dent. J., 16:297, 1950. 4. Stephan, R. M.: J. Dent. Research, 22:63, 1943.

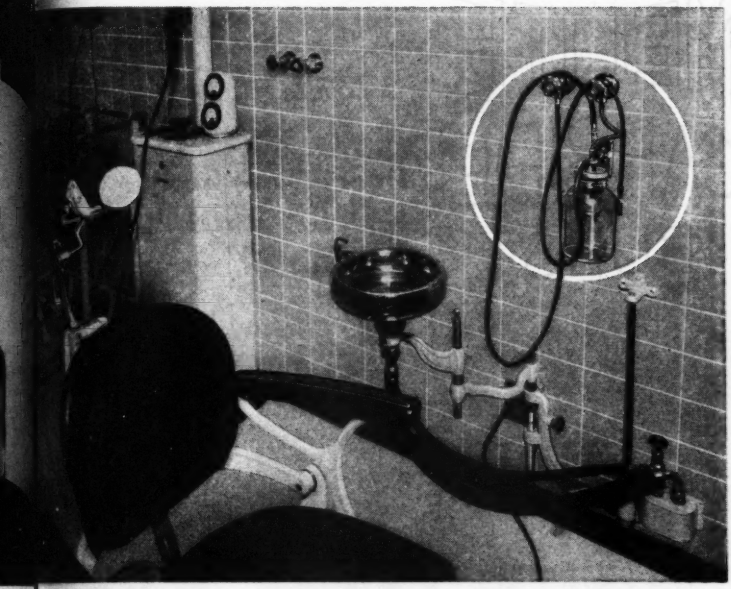
Amm-i-dent, Inc., Jersey City 2, N. J.
21-J

(*Amm-i-dent's record of caries reduction was made on regular twice-a-day brushing)



Available at all Drug Counters

Amm-i-dent



A 'MUST' for Your New Dental Offices or Clinic—

McKESSON CENTRAL SUCTION AND COMPRESSION

It's being designed and built into most all new modern dental offices and clinics. And why not?

It's more economical and efficient . . . better looking and more up-to-the minute . . . and more convenient for your chairwork.

Built right into the wall . . . Handy . . . Tubes and apparatus out of sight!

Before you OK plans for your new offices or clinic, let us send you our catalog . . . and show you how others have designed McKesson Central Systems into their places.

A card or letter to us will do it! And why not act now while these Systems are still available at the old prices?

McKesson
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COMPANY
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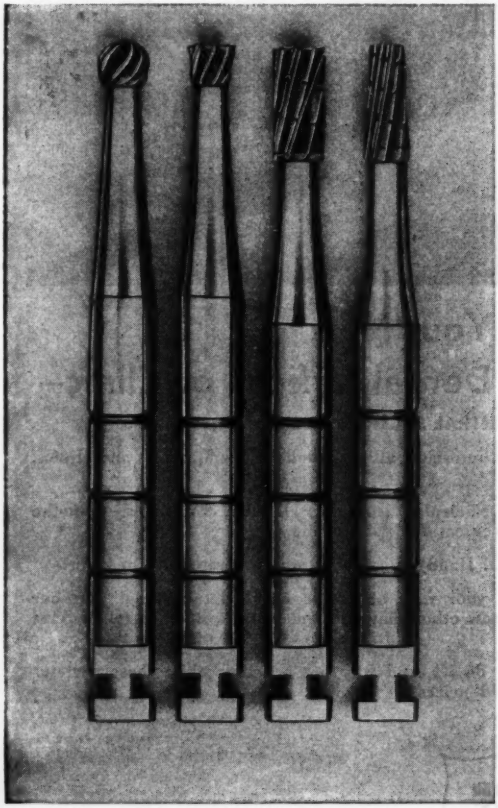
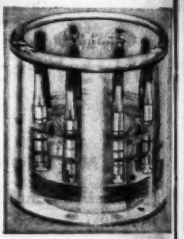
MELITE CARBIDE BURS

Precision-sharp
Spiral **cutting edges**
Diagonal **cross cuts**



for
Smoother
Faster
Cutting



Assortment of
8 Carbide Burs
in Self-locking
Lucite Cases . . .

★

Ask your local dental dealer

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MELITE PRODUCTS CO.

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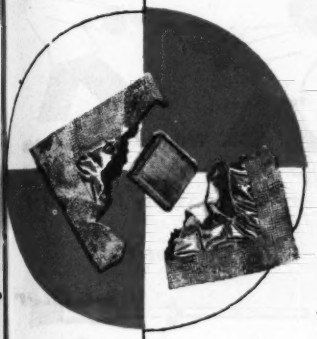
Box 496, Detroit 4, Michigan



WHEN LOCAL LEVELS COUNT...

superior topical penicillin therapy for mouth and throat infections with ORYGENE*

Penicillin Chewing Troches, Parke-Davis
10,000 units of crystalline potassium penicillin-G in a peppermint-flavored chewing gum base

The true chicle base of ORYGENE Penicillin Chewing Troches overcomes the disadvantages of tablets, lozenges, ordinary troches, and chewing gum substitutes—i.e., rapid disintegration, swallowing, premature dissolution and crumbling. The familiar consistency and flavor of peppermint chewing gum encourages patients to retain and to chew ORYGENE for the prescribed period. This stimulates flow of saliva and permits prolonged release of penicillin. Infected tissues are bathed in high concentrations of penicillin, continuously renewed from the gum base and widely dispersed by the mechanical effect of chewing.

indications: Prophylaxis and treatment of infections of mouth and throat due to Vincent's organisms and other penicillin-sensitive pathogens—ulceromembranous stomatitis and gingivitis, pericoronitis, secondarily infected cankers. Administered prior to and following tonsillectomy, tooth extraction, and other surgical procedures, ORYGENE is of value in preventing secondary infection.

dosage and method of use: One ORYGENE Penicillin Chewing Troche should be chewed at a time, preferably for 30 minutes. In treating infections due to Vincent's organisms, a daily total of 4 to 6 ORYGENE Troches will usually produce clinical results within 24 to 48 hours. Treatment is continued for several days thereafter to prevent relapses.

packaging: Available on prescription in packages of 12. Each ORYGENE Troche—is individually and hermetically sealed in aluminum foil. No refrigeration is required.

PARKE, DAVIS & COMPANY

*Trade Mark

. . . tested and established in laboratory use over 30 years!

CloverLeaf

IMPRESSION PLASTER

Green Clover Leaf XX Plaster with Wintergreen flavor

White Clover Leaf XX unflavored

Fine grained for faithful reproduction of every detail of teeth and tissue. Rapid, accurate set; breaks with a clean fracture.

HARDITE MODEL

Holds the case to unchanging dimension regardless of curing temperature. Laboratory-controlled manufacture assures consistent uniformity, positive reproduction for perfect fit and articulation.

ALSO: *Standard Set Plaster; Hard Plaster; Laboratory Plaster; Vulcanizing Stone; Flasking Compound.*

FREE SAMPLES

H. B. WIGGIN'S SONS CO. OH-9
Bloomfield, N. J.

Please send free sample of
CLOVER LEAF XX Impression Plaster
___Wintergreen ___Unflavored

Dr._____

Address_____

City_____ State_____

My supply house is_____

Crescent Polisher

PATENTED

- Permanently Mounted

Won't Come Loose

- Assures Safety for Patient
- Protection for YOU

Crescent DENTAL MFG. CO.
1839 S. Pulaski Road
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REBUILT LIKE NEW

CONTRA ANGLES expertly rebuilt with genuine parts **$5.50**

DORIOT HANDPIECES
DENSCO-TAPER-ANGLES
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estimate on request

Save high cost of new replacements. Ship to us—pay AFTER you receive REBUILT handpieces. SATISFACTION GUARANTEED.

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WANT A SAMPLE BS POLISHER FOR TRIAL?

The best way we know to prove the efficiency, smoothness, coolness and comfort of the BS Polisher is to send you a sample. There is no charge or obligation. Then you'll have the proof we want you to have. Send for your sample today.

Young Dental Mfg. Co., St. Louis 8, Mo.
Yes, send me a sample BS Polisher.

Dr. .....

Address .....

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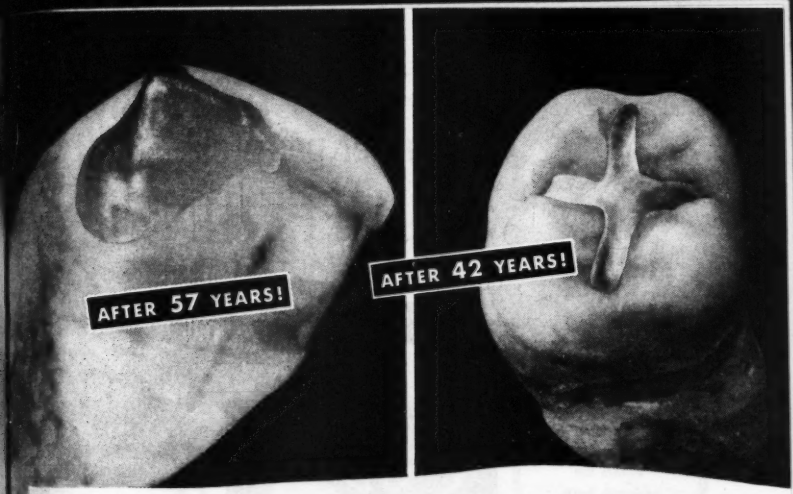


forever faithful! FOREVER NEW!

—eminently contourable!

Modern Operative Dentistry no longer speaks of the replacement of lost tooth structure as the making of a filling. Its new and higher concept is not merely to stop up a cavity, but to restore a tooth to form and function.

Correct form is essential to efficient function. Nature has designed the teeth not as independent organs, but as *interdependent members* of the masticating mechanism. Each tooth has a distinct form, adapted to its specialized function, and this form must be reproduced accurately if the tooth is again to function efficiently.

And cohesive Gold Foil does that eminently well. By virtue of its cohesiveness, manipulative softness, and pliability, it is capable of reproducing the most minute anatomical details — making the entire operation so truly lifelike and beautiful as to rival the finest creations of Nature's own handiwork.

We should gladly send you further data about this wonderful material. Simply mail the lower portion of this page with your card or letterhead to **Morgan, Hastings & Co.**, 2314 Market Street, Philadelphia 3, Pa. — Established 1820.

GOLD FOIL — the only restoration without a weakness!

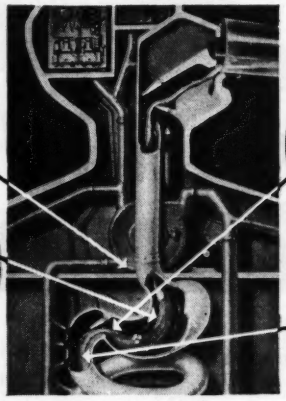
Give faster pain relief with BUFFERIN

ACTS TWICE AS FAST AS ASPIRIN

WITHOUT GASTRIC DISTRESS!

1. BUFFERIN enters the stomach here.

2. BUFFERIN exerts its antacid effect, lessening the possibility of gastric distress.



3. BUFFERIN helps dilate the pyloric valve, promptly leaves the stomach.

4. BUFFERIN's analgesic component is absorbed into the blood *twice as fast as aspirin*, relieves pain.

When you prescribe BUFFERIN to your patients you assure *faster relief of pain*. Clinical studies[1] show that within ten minutes after BUFFERIN is ingested, blood salicylate levels are as great as those attained by aspirin in twice this time. That is why BUFFERIN *acts twice as fast as aspirin.*

BUFFERIN has *greater gastric tolerance.* BUFFERIN's antacid ingredients provide protection against the gastric distress so often seen with aspirin.[1] BUFFERIN, therefore, is especially suited for use when prolonged use of salicylates is indicated.

1. Effect of Buffering Agents on Absorption of Acetylsalicylic Acid J. Am. Pharm. A., Sc. Ed. 39:21, Jan. 1950.

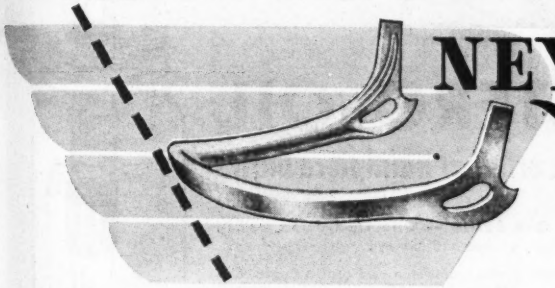
In vials of 12 and 36 and bottles of 100. Scored for divided dosage. Each BUFFERIN tablet contains 5 grains of acetylsalicylic acid with optimal proportions of magnesium carbonate and aluminum glycinate.

BUFFERIN
is a trade-mark of the Bristol-Myers Company

Accepted COUNCIL ON DENTAL THERAPEUTICS AMERICAN DENTAL ASSOCIATION

A product of BRISTOL-MYERS COMPANY
19 West 50 St., New York 20, N. Y.

THE *NEW SLOPE*



NEY Wing BAR

so *much* easier to adapt . . .

so *much* more comfortable in the mouth

To arrive at this new and anatomically correct shape, Ney waxed up lingual bars on a comprehensive series of practical models . . . then cast the bars and measured the exact slope of the tissue surfaces. This ideal slope angle . . . approximately 60° from the vertical . . . is now built into all Ney Wing Bars. It saves time, facilitates adaptation, and brings the retention end of the bar down on the model naturally without preliminary bending. The patient enjoys cast bar perfection of fit with more tongue room and precision conformance to natural mouth contours.

NOW **there are 5 good reasons why . . .**

Ney Wing Bar popularity grows year by year

NEW SLOPE follows natural tissue contour . . . for easier, quicker adaptation.

Original STREAMLINED design . . . less bulky, no sharp edges, more comfortable.

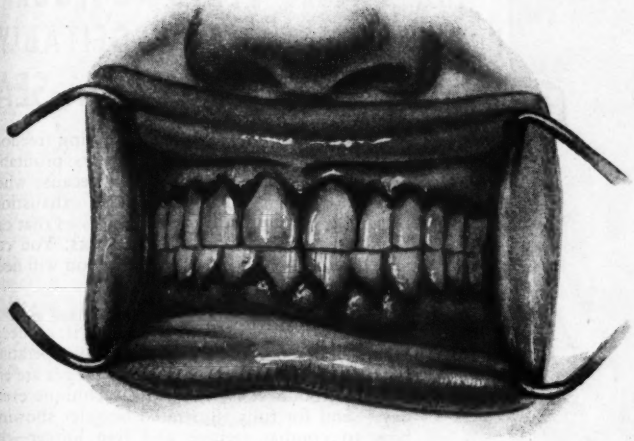
DENTURE-CLASP metal . . . tough, strong . . . stiffest precious metal bar available.

Tailor-made FINISH LINES with exclusive Ney Finish Line Clips.

Unique NEY WING will not twist or loosen.

Born of Research NEY GOLD *Proved by Test*

THE J. M. NEY COMPANY • HARTFORD 1, CONNECTICUT

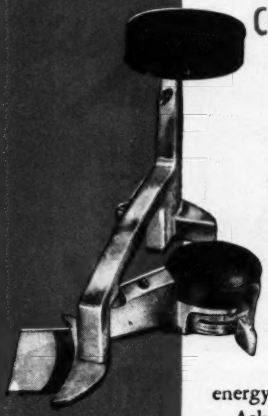


in Vincent's infection:

Rapidly effective and well tolerated, Terramycin has proved particularly valuable in Vincent's infection of the gingiva and buccal mucosa. *Terramycin Troches* may be used as the sole medication in mild infections, while in severe or deep-seated infections topical therapy is recommended as an adjunct to oral treatment with *Terramycin Capsules, Elixir* or *Oral Drops.*

ANTIBIOTIC DIVISION **Pfizer** CHAS. PFIZER & CO., INC., *Brooklyn 6, New York*

ADD 5 TO 10 YEARS TO YOUR PROFESSIONAL LIFE···PROFITABLY··· COMFORTABLY WITH ROTA-SEAT

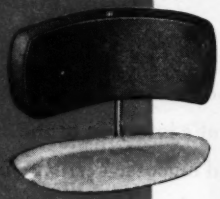


Rota-Seat gives you complete operating freedom —SITTING DOWN. It will add years, profitable years, to your professional career, because when you work sitting down you banish exhaustion, backache, bending and twisting stresses that can build up to serious organic disorders. You can take care of more patients, too, for you will need fewer rest periods.

Rota-Seat is the ORIGINAL operating seat for dentists (not merely a rest stool), you sit on deep, foam rubber, and roll easily to any operating position. More and more dental colleges are endorsing Rota-Seat's "sit-down" technique every day—send for fully illustrated booklet showing how to combat fatigue and live longer—the energy-saving, Rota-Seat way.

Ask your dental supply dealer to show you how easy it is to operate from a Rota-Seat in *your own* office. Thousands of satisfied users.

EXTRA COMFORT FOR YOUR PATIENTS, TOO . . . .



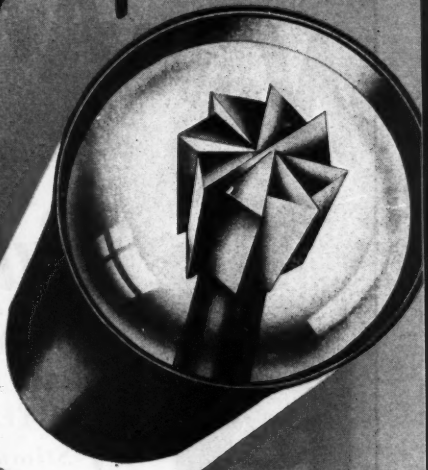
Instead of the patient holding his head in one position, forcing you to operate from many different, uncomfortable angles, the new Rota-Seat Head Rest permits turning the patient's head to offer easier access for the dentist, thus proving more comfortable for patient and dentist alike. The Rota-Seat Head Rest is adjustable to fit *any* type or make of chair. Made in one piece, large enough to accommodate any size head, of 1¼ in. thick foam rubber, covered with black vinylite to resist acids, water, oil, and all solvents, it can easily be kept clean by ordinary washing. Ask your dental supply dealer for details, or write us direct, giving your dealer's name.

rota-seat INC.

DENTAL EQUIPMENT SPECIALISTS
4606 W. 21st St. - Cicero 50, Ill.

Individually Inspected . . .

Every Ash Bur you purchase has been individually inspected by trained examiners at every stage of manufacture. This individual inspection is your assurance that Ash Burs are as sharp — as perfect — as care and skill can make them. For the utmost in easy, speedy pain-free cavity preparation, for your convenience and your patient's comfort always use Ash Burs.



Ash BURS

NEW SIZES!

Ash Miniature Burs — Round (for use in Miniature Head handpieces) are now available in sizes 6 and 8.

ASH 'B.T.' (BRACKET TABLE) BUR ASSORTMENT

Assortment comprises: 7 doz. Ash Burs for Angle handpiece, 3 doz. Ash Burs for Straight handpiece, and 2 doz. Ash Miniature Burs (12 doz. Ash Burs in all). Stand is curved to fit the rim of the bracket table and economize space. Black or Cream.

Claudius Ash, Sons & Co. U.S.A. Inc.

127-131 Coit Street — Irvington 11, New Jersey

Trade Distribution Agents in U.S.A. for
AMALGAMATED DENTAL ENGINEERING INDUSTRIES LTD., Walton-on-Thames, England

THE NAME "ASH" HAS IDENTIFIED FINE DENTAL INSTRUMENTS FOR OVER 130 YEARS.

The Porcelain Tooth Of Greater Strength

You do not have to put up with excessive breakage in modern transparent enamel teeth! If you are one of many having undue breakage, then switch to the original of all transparent enamel teeth — Myerson's True-Blend — more beautiful and stronger than any of its imitators, stronger even than the old opaque type of tooth.

Read what these dentists and laboratories say, based on their actual experience with Myerson's teeth.

From a Boston dentist . . .
who has been wearing Myerson's True-Blend in his own mouth since 1940: "I have remade the case several times but always use the same teeth. I've had no breakage. Personally we use Myerson teeth exclusively in my office because they are stronger and more beautiful."

From a New Jersey Laboratory . . .
"From the technician's angle — I have very little breakage with Myerson's teeth."

From a dental clinic in Chicago . . .
"Everyone in the circle agreed with me 100%. They had far less checked teeth trouble with Myerson's than with any others."

These and many other testimonials are from actual letters in our files.

Myerson's TRUE-BLEND

MYERSON TOOTH CORPORATION
Cambridge 39, Massachusetts, U.S.A.

tested in our lab not in your office

D-P ELASTIC IMPRESSION CREAM —a superb medium for *any type* impression—is tested *before* you use it to insure consistent results time after time.

AND EQUALLY IMPORTANT D-P Elastic Impression Cream has had a CONSISTENT FORMULATION for years. The package you use today will give you exactly the same results as the package you used last month or last year!

CAN YOU THINK OF A BETTER REASON for ordering from your Dental Dealer NOW!

dental perfection co.

543 West Arden Ave. • Glendale 3, Calif.

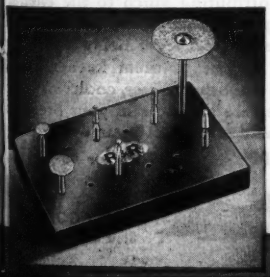
...Buy 6... Get 7

...in the

CUTWELL DIAMOND INSTRUMENT *Economy Assortment*

Here is a worth-while inducement for you to discover for yourself the superior cutting efficiency and durability of R&R Cutwell TRIBOND Diamond Instruments. For in addition to any selection of six instruments you order at the money-saving half-dozen rate, you can obtain FREE any additional instrument of your choice from the comprehensive Cutwell line, no matter what its regular price!

Take the first opportunity to look over the wide range of types and sizes of instruments available, so you can make your own selection and take advantage of this generous "get acquainted" offer. The handy instrument holder is included.

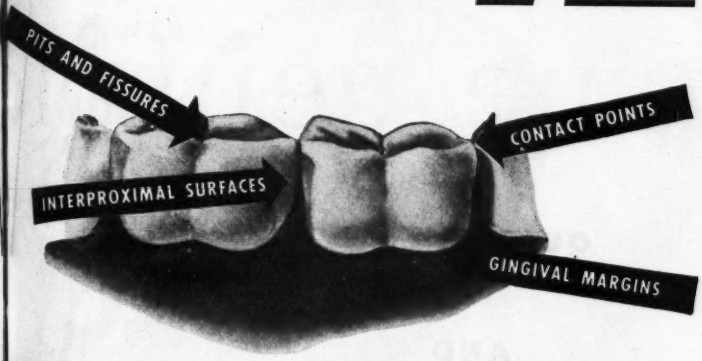


THE RANSOM & RANDOLPH COMPANY • Toledo, Ohio

95% Of All Dental Caries Start In *These Four* Areas

ARE YOU SURE

you are protecting *all four?*



With the TOPI-FLUOR THERAPY KIT* for topical sodium fluoride application, you can be certain you are reaching — and effectively treating — all areas where caries occur. Topi-Fluor therapy, applied by the wax impression method:

- **HOLDS Topi-Fluor Cream in contact with all tooth surfaces. Can't drain off like ordinary liquids.**
- **PUMPS Topi-Fluor Cream (2% sodium fluoride in stable solution) into all interproximal spaces.**
- **PENETRATES pits and fissures, visibly coats all tooth surfaces.**
- **REACHES contact points through manipulation of the wax impression.**
- **PROVIDES a professional method that saves up to 50% of your time.**

For economy, kits are available in a number of sizes. Order from your Dental Supply House today!

*Patent Pending

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QUICKLY

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THE SCIENTIFICALLY SIMPLIFIED METHOD OF DENTURE CONSTRUCTION

available through your
DURALLOID LABORATORY

HOW TRUE CENTRIC IS RECORDED WITH CENTRIMETRICS

4 quick steps to perfect registration

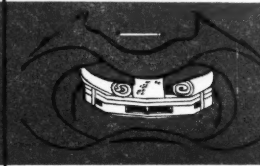
that's all there is to it!

STEP 1

Vertical relation determined.

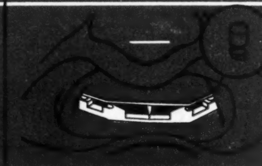
STEP 2

Laboratory-mounted instrument set at proper vertical relation.



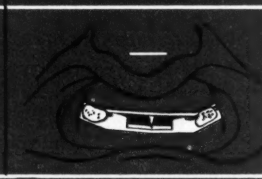
STEP 3

Resilient balancing studs inserted and true centric recorded.



STEP 4

Three-point index obtained with pre-formed compound blocks, and bases are returned to laboratory.



The resiliency of the balancing studs used in Step No. 3 is the key to the simplicity and success of Centrimetrics. The spring-action seats the bases firmly on the ridges, causes the muscles to function naturally as centric is recorded, and assures proper tissue displacement. This unique feature of Centrimetrics guards you against remakes and re-try-ins due to faulty registration . . . saves you time with consistent accuracy . . . greatly increases patient comfort and satisfaction.

send for your copy of... **CENTRIMETRICS IN ACTION**—

Centrimetrics can be applied to all types of prosthetic appliances, and for the correction of occlusion on the natural dentition. For complete information about this tested and proved method of denture construction—your free copy of CENTRIMETRICS IN ACTION—simply write "Centrimetrics" on a postcard with your name and address, or on your card, letterhead or statement, and mail it to us today.

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Carefully controlled viscosity in Perma-Grip Adhesive Denture Powder permits exceptional holding power without danger of irritation.

ABILITY to hold dentures firmly in place is of first importance in evaluating an adhesive denture powder. But it is not the only consideration. Equally important is the assurance of freedom from irritation of the tissue surface.

These qualities of *firmness* and *gentleness* are admirably combined in Perma-Grip, the improved adhesive denture powder made by the Prophy-lac-tic Brush Company.

Perma-Grip is made with high quality karaya gum, carefully processed into a bland, milky-white powder. This powder forms a smooth, comfortable cushion that resists "balling up" under the denture. The color and taste are pleasant. The pH is mildly alkaline.

To help your patients through the critical period of adjustment to a new denture, you can confidently recommend Perma-Grip.

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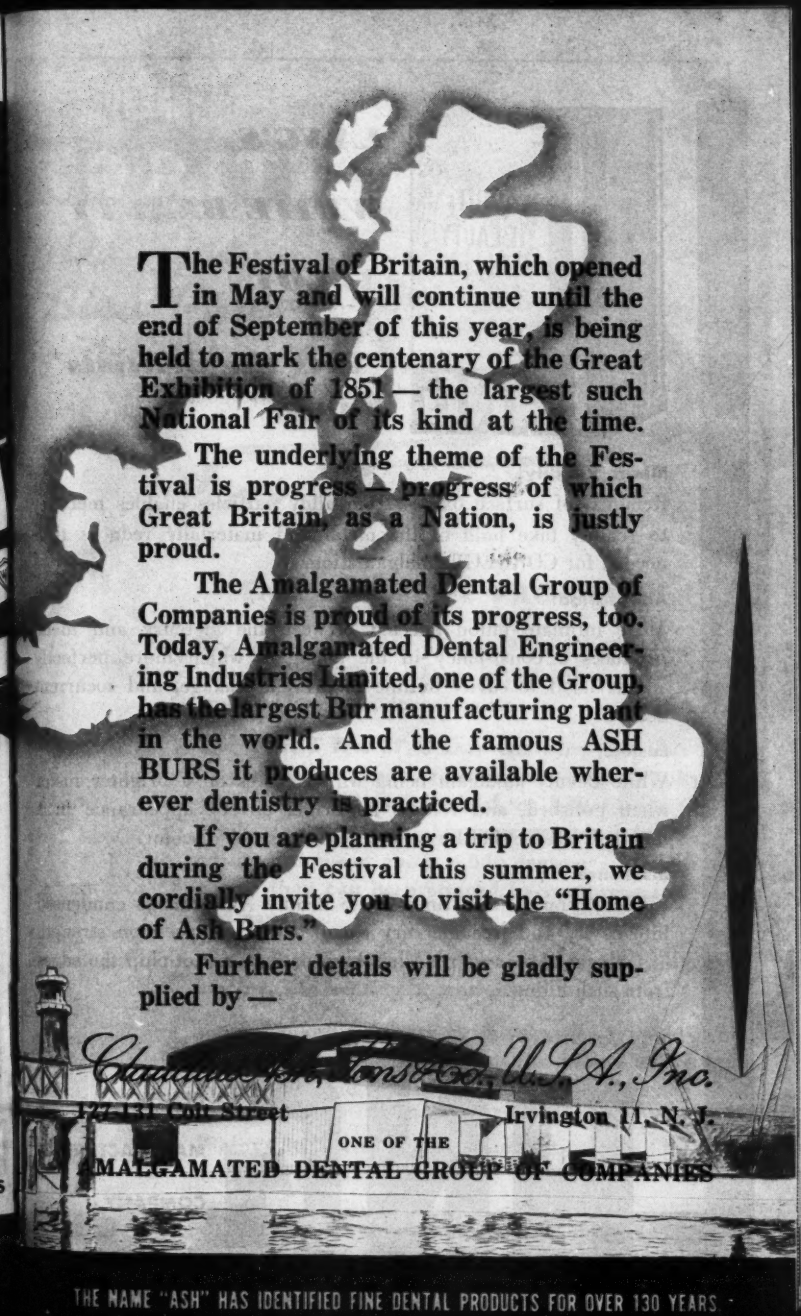

The Festival of Britain, which opened in May and will continue until the end of September of this year, is being held to mark the centenary of the Great Exhibition of 1851 — the largest such National Fair of its kind at the time.

The underlying theme of the Festival is progress — progress of which Great Britain, as a Nation, is justly proud.

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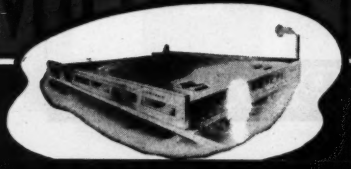

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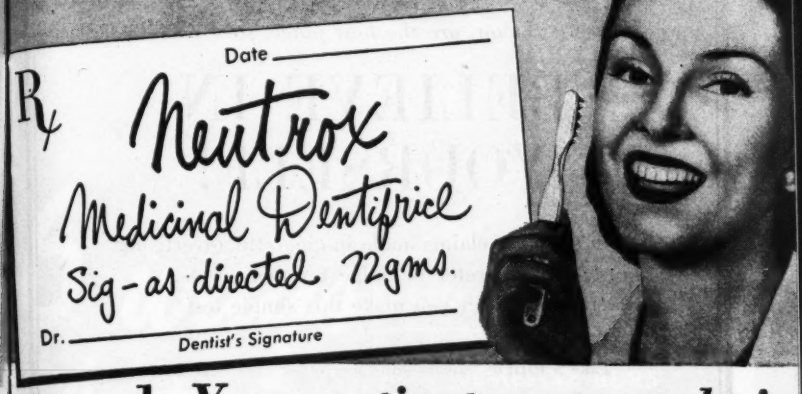

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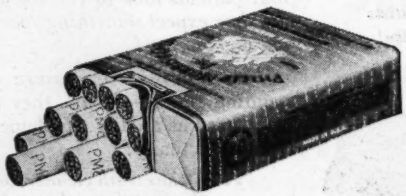

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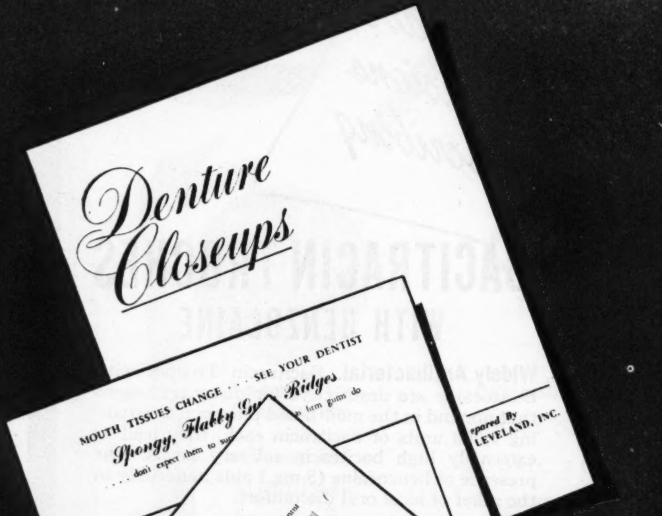

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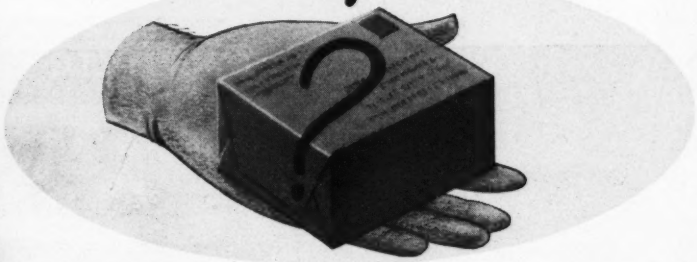

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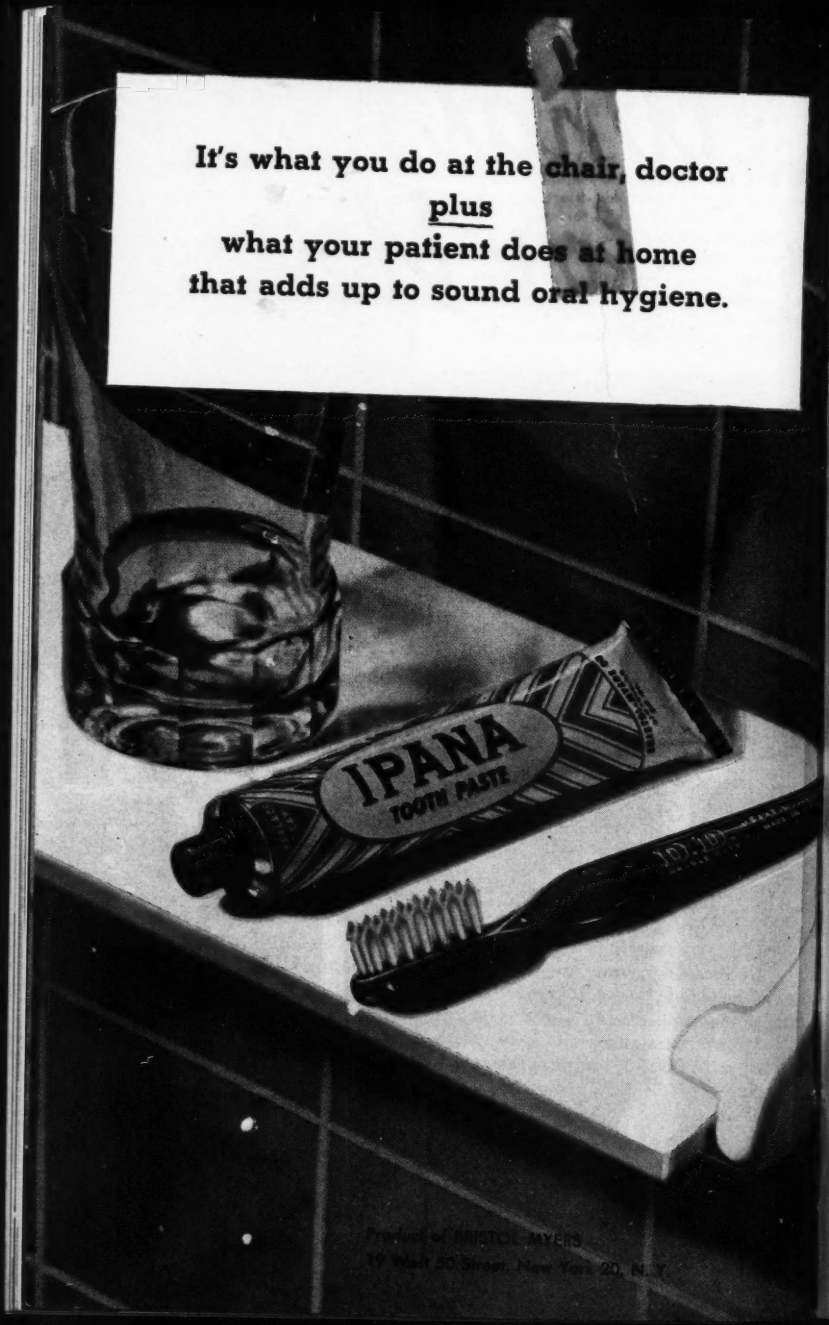
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